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DOCUMENT RESUME

ED 190 979	CG 014 655

TITLE	Elder Abuse: The Hidden Problem. A Briefing by the Select Committee on Aging, House of Representatives, Ninety-Sixth Congress, First Session (Boston, Massachusetts, June 23, 1979).
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
REPORT NO	96-220
PUB DATE	80
NOTE	119p.: Not available in paper copy due to small type size.
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Aggression: Emotional Response: *Family Problems: *Gerontology: Government Publications: *Hearings: Hostility: Legislation: *Older Adults: Physical Disabilities: Psychological Needs: Social Services: *Violence
IDENTIFIERS	*Congress 96th: *Elder Abuse

ABSTRACT

This briefing by the Congressional Select Committee on Aging was designed to gather information on the physical and psychological abuse of the elderly. A number of witness reports are included, testifying to the seriousness and extent of the problem of elder abuse. It is pointed out that many victims refuse to admit abuse: public discussions of elder abuse may encourage victims to seek aid. Actual cases of abuse are presented with the difficulties faced by agencies in dealing with them. Witnesses also discuss social work, legal and ethical issues involved. The incidence and nature of elder abuse are described along with characteristics of the abused elder and potential causes of abuse. Appendices include a survey of professionals and paraprofessionals on elder abuse in Massachusetts, a review of recent literature on elder abuse, an analysis of protective service systems for handling abuse cases, recommendations for abuse reporting and legislation, and a testimony on Connecticut's Elderly Protective Services Law. (NRB)

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ELDER ABUSE: THE HIDDEN PROBLEM

A BRIEFING

BY THE

SELECT COMMITTEE ON AGING
U.S. HOUSE OF REPRESENTATIVES
NINETY-SIXTH CONGRESS
FIRST SESSION

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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JUNE 23, 1979, BOSTON, MASS.

Comm. Pub. No. 96-220

Printed for the use of the Select Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
58-666 O WASHINGTON : 1980

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ELDER ABUSE: THE HIDDEN PROBLEM

SATURDAY, JUNE 23, 1979

U.S. House of Representatives,
Select Committee on Aging,
Boston, Mass.

The committee met, pursuant to notice, at 9:30 a.m., in room 208, Suffolk University Law School, 12 Temple Street, Boston, Mass., the Hon. Robert F. Drinan (acting chairman of the committee) presiding.

Member present: Representative Drinan of Massachusetts.

Staff present: Kathleen Gardner, Professional Staff Member, Select Committee on Aging.

OPENING STATEMENT OF CHAIRMAN ROBERT F. DRINAN

Mr. Drinan. The physical abuse of our elderly is a notion that shocks and disturbs us all. As Mr. Bergman indicated it is one we don't like to admit exists in our society. When I was advised of the findings of the Legal Research and Services for the Elderly survey, I contacted the chairman of the Select Committee on Aging, Congressman Pepper, and asked if we could hold a briefing in Boston to gather more information to compile a report for the committee. He shared my concern and gave this committee the go ahead.

As indicated, this is the first time that any Congressional Committee has held hearings dealing exclusively with the physical and psychological abuse of the elderly. While a number of prominent individuals and groups have begun to study the situation, there is yet very little hard information about the topic. We are, in effect, taking a very important first step here today. It is my hope that this briefing can increase the public's awareness of the extent of the problem. At the same time, I hope that we can begin to amass a coherent body of facts and information in the area of elderly abuse.

Today, we will hear from spokespersons of the Legal Research and Services for the Elderly project, who will outline the findings of their survey. All of the evidence and testimony presented here today will be compiled in a report which I will present to the Select Committee on Aging. Following the presentation of the report, I and other members of the Aging Committee will decide what role, if any, that Congress should play in alleviating this situation. I am very pleased to have present with us today Dr. Thomas Mahoney, the Secretary of the Massachusetts Office of Elder Affairs. I want him at this time, if he wishes, to make an opening statement.

OPENING STATEMENT OF DR. THOMAS H. D. MAHONEY, SECRETARY, DEPARTMENT OF ELDER AFFAIRS, COMMONWEALTH OF MASSACHUSETTS

Dr. Mahoney. Thank you very much, Congressman. I had the great pleasure of meeting the Congressman a week ago in Washington. The cooperation and help which he extended were something that I will not readily forget. I'm very pleased that my agency saw fit to fund this survey, this body of material that we will be discussing here this morning and I would like to assure one and all that we are very serious about ongoing studies as I'm sure will be pointed out through the course of the day.

We are only at the tip of the iceberg and there is so much we can learn. The findings in this survey are only preliminary but they indicate that elderly abuse is a very serious problem. It is rather clear that follow-up is necessary to ascertain where and how abuse cases are uncovered and what methods we should delineate for their handling. The area of abuse or the neglect of elders, unfortunately, could become more prevalent as the years ago by and as the problem becomes more and more serious and intent. It is the intention of your secretary to see to it that a bill will be filed in the coming session of the Massachusetts Legislature for which bills have to be in by early December of 1979. We will be working on a good comprehensive bill to go further into this type of situation and it's perfectly obvious that a service system which is capable of handling the reports would have to co-exist with the reporting law.

Some of the home care agencies, and area agencies on aging have developed or are in the process of developing a service mechanism to intervene when an elder is in danger, when they are endangering others willingly or unwillingly or when they are unable themselves to deal with one of these situations. This is a service mechanism that falls under the broad category of protective services and usually consists of a Massachusetts social welfare person who serves as a crisis intervention person and also provides coordination of other services as they are needed.

Very briefly, the area of abuse and neglect of elders is a very serious problem for those who are involved. In other words, it is a very serious problem for the abused elders, their families, and for their friends. It is also a matter of great concern to the providers of medical, legal and social services. Issues in recognition of abuse and the treatment for their resolution are, of course, very much undefined at this particular point. Through the Legal Research and Services for the Elderly project, the in-house protective service and committee, the Department of Elder Affairs has already made some preliminary planning strides. During the next six to twelve months, we will be taking a deeper and a harder look at elder abuse. We will endeavor to develop the beginning of a rational, comprehensive effort toward alleviating this terrible problem of abuse or neglect of elders.

As many of you know, we are in our infancy in the recognition of this problem. It is only 15 or 20 years ago that child abuse suddenly came upon us as a society. So, as Mr. Bergman said, this is a very,

very serious subject. We take no pleasure in the fact that this evidence has been uncovered. We have to be realistic enough to appreciate the fact that it exists. We have to recognize it and we have to do everything in our collective power to rectify it.

Mr. DRINAN. Will our first witness, Mr. Bergman, please come forward?

STATEMENT OF JAMES A. BERGMAN, REGIONAL DIRECTOR, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LRSE)

Mr. BERGMAN. Thank you very much, Congressman. I would like to reiterate one point that was made earlier by Secretary Mahoney. Child abuse was "discovered" so to speak in the 1960's and spouse abuse was "uncovered" in the 1970's. I think we're at the point where elder abuse is going to be "discovered." This briefing is especially important because it will focus attention on the fact that elder abuse does exist. Further, as with child abuse and spouse abuse, until the public policymakers see that elderly abuse exists, ways will not be suggested for treating that problem. We saw that spouse abuse was not generally condoned but certainly not widely condemned until women's groups began in the 1970's to make an issue out of it, to call for legislative hearings, to go to the news media and present the fact that wife battering was occurring and in much greater frequency than anyone had ever guessed. I think it was only at that point that many women especially and, to a lesser extent, men began to come forward and admit they were in fact being beaten, battered and abused. At that point, as more and more media attention began to be focused on this, as more and more legislative hearings were held, persons were no longer as ashamed as they had been to come forward.

This briefing is certainly a way of beginning to focus more attention, more public attention, more policymaking attention on the problem of elder abuse. This is one of the reasons that we wanted so desperately to have a briefing like this—because many older people refuse at this point, as our survey indicated, to come forward and admit that abuse is occurring and is affecting them and that they are being abused. There are any number of reasons that we can surmise why elders don't come forward: shame at being an abuse victim; fear of retaliation by the abuser; belief by the victim that he or she is the major cause of the abuse occurring and, therefore, deserving of what he or she gets. The fact is, no one deserves to be abused. The fact is no one enjoys being beaten. There seems to be a myth that some people get their kicks out of being abused. I think that we're very misled if we believe that. Circumstances may be set up in such a way that elders feel they can not avoid the abuse; they may face real difficulties in extricating themselves from the abusing situation. But enjoying it? Relishing it? Far from it. It is so important to discuss elder abuse publicly, because it is only then that victims of abuse are likely to come forward to agencies who can, in fact, deal with these issues. Only in this way can elder abuse be addressed effectively. To the extent that this briefing serves to stimulate a public discussion, it will have accomplished its purpose.

Persons who are presenting testimony today will present evidence that elder abuse is much more extensive than any of us thought. They will describe actual cases of abuse that have occurred, that they've dealt with, and the difficulties that each agency has in dealing with those cases. Probably the most difficult cases in the "protective services area" are those in which an elder has been abused.

Furthermore witnesses will discuss the social work, the ethical and legal issues involved in dealing with elder abuse cases. We hope that this written and verbal testimony today will provide sufficient evidence that the problem is as great as we think it is and will also provide a firm foundation for further study and for further action on the problem.

However, throughout this hearing you're going to hear people raising many questions. Indeed, there will be more questions than answers and that's not really surprising—any time an issue is new, everyone dealing with it has much trepidation about going too far, overstating the case. We ask why, how, who's doing it? Those are questions which are not going to be answered today. We're only beginning to take a look at these questions. But again, this briefing provides a starting point for that. As a former Lexington resident once said and I'm paraphrasing, "If the war against elderly abuse is to start, let it begin here."

James Thurber once wrote that there are two kinds of light—the glow that illuminates and the glare that obscures. Throughout the last few months as our program has worked on elderly abuse, we've attempted to provide a glow that illuminates the issue; we've attempted very much to avoid the glare of publicity. We know that it's very easy to sensationalize elder abuse. It's a horrifying topic, but the problem with sensationalizing is that you set yourself up for negative reactions. As you will hear today from other persons who testify, most cases of elder abuse are not single instances; abuse is a repetitive act. These cases are ones that go back years and years in some instances. To think that a fast reaction by a caseworker or public policymaker is going to solve such cases is very wrong. This is one of the reasons we're avoiding trying to sensationalize this issue. We do need a long-term effort to deal with these cases on an individual basis, as well as on a policy basis. Fast knee-jerk reactions are not going to help us address this problem area.

The speakers who follow me will provide much more specific information on individual cases of elder abuse and on research which has been begun in this area, but as an introduction to the problem, I would like to relate one case which I think is a classic. It was, fortunately, handled successfully and also handled properly by the worker, which is something that is not always the case.

This case, I guess, really began about four years ago in central Massachusetts when a young woman and her husband separated and got a divorce. The couple had been living with the husband's mother and had a child of their own. When the couple separated, interestingly enough, the husband left the home but the daughter-in-law stayed there with her child and mother-in-law. The daughter-in-law at that time made the statement to the mother that since she couldn't take out her venom on her ex-husband, she was going to take it out on the woman. Then she proceeded to do so. She periodically beat her mother-in-law and cashed her Social Security check, giving very little back to the elderly woman. The mother-in-law also suffered mental anguish. The daughter-in-law, at times, made food for the woman, who was not healthy, who was not terribly mobile, and simply put it on the floor, saying, "You're nothing more than an animal; you ought to eat like one." The daughter-in-law contributed virtually nothing to the support of the older woman or that family unit. The money for the rent was paid out of the social security check, if it was paid at all. The daughter-in-law had alcohol problems and was using a good portion of the money for alcohol. The older woman was obviously in a very difficult situation. Fortunately, about four months ago, a neighbor called the Visiting Nurse Association and indicated that the house had deteriorated substantially, and they thought that maybe the older woman was having health problems as a result of it.

When the nurse went to the home she discovered not only health problems but also what looked like a potential case of abuse. She called the protective services worker of the Home Care Corporation in that area. Fortunately, that Home Care Corporation is one of the few in the state that has a protective services program. Had it not been for that, this story would have had, I think, a very different ending. But the protective services worker went in, established in her mind that abuse was in fact occurring, that malnutrition was occurring and talked with the elderly woman about it. She established a relationship with her but was not able to convince the woman that she ought to do anything about the situation itself. The worker was able to convince her that medical treatment was necessary but was not able to get any further than that. The worker spent considerable time over the next four months working with that older woman, talking to her, establishing a relationship with her, but was still not able to convince her to take any action to protect herself. Finally, about a month and a half ago, the landlord threatened to evict everybody from the house because the house was so poorly cared for, so deteriorated. Threatened with eviction, the older woman finally said she would act. If her choices were to be thrown out on the street or to possibly remain in this home by herself, then she decided she would take the latter course.

At that point, the protective services worker contacted the legal services attorney for the elderly in that area. That attorney, representing the older woman, went into court and got a vacate order which required the daughter-in-law to leave the premises immediately as well as to refrain from abusing the older person. At that point, the daughter-in-law was forced to leave the home, did so, and was given an opportunity for a hearing. She did not contest the order and it was made permanent for a year.

That could have been the end of the story. Fortunately, again, this was a situation where the Home Care Corporation and the other agencies in the community had been dealing with the case over a long period of time and immediately brought in extra services to provide some support for that elderly woman, now living alone in the house. She got homemaker's service, chore service to help clean up the house, transportation to medical care, and was advised of the continued availability of legal services if the daughter-in-law should violate the court order. The visiting nurse and the protective services worker continued to go into the home on a very regular basis. Davis after that vacate order was issued, the woman was still having great fear about what would happen around 4 or 5 in the afternoon which was the normal time for the daughter-in-law to come home from work. She has not come home, however, and now, 3 or 4 weeks later, the woman seems to be getting used to the situation, and seems to be getting along nicely. Her blood pressure, which had skyrocketed to a very dangerous level, is now working its way slowly back down and it appears that the situation will have worked out very nicely.

This case illustrates some general findings that we've made on elder abuse. In this case, as in many others, the older person was not very mobile; she was somewhat dependent upon the person who was abusing her; she was being financially exploited; she was being beaten as well as mentally abused and the abuser herself also had a very serious problem—alcoholism. The abuse continued for a very long period of time. We also see that the victim was not the person who reported the abuse case. It was a third party, a neighbor. The victim did not want to do anything about that abuse situation initially. It took extended time and contacts with workers before the elder agreed to protect herself. Had the workers not been keeping that regular contact, the eviction probably would have occurred and the situation would undoubtedly not have improved at all.

These factors appear to typify many abuse cases as other speakers will relate today. I think the thing that's not typical about this case is that it was successfully resolved. That is not at all typical of cases of this nature.

Many of the remedies for elder abuse cases must originate with state and local action and that will again be discussed by many other people today so I won't dwell on it. I would like to suggest three steps that I think can and should be taken at the federal level.

One, I hope that as a result of this briefing today, the House Select Committee on Aging will conduct further hearings to be held in Washington and across the country on the issue of elderly abuse. This is a nation-wide problem and the more attention that can be focused on it, the more information that can be gathered, the better all of us are going to be in terms of being able to respond to it.

Second, since elder abuse is just being uncovered, much more research is needed as well as special projects to test various methods of locating persons who are being abused and of actually handling these cases. If it is possible, the Congress should try to encourage both the Administration on Aging, the National Institute on Aging and possibly the Law Enforcement Assistance Administration to begin targeting some of their funds to issues of elder abuse.

Third, Title XX of the Social Security Act provides normally 75% federal reimbursement for social services provided through state and local agencies under contract. Since the scope of elder abuse is still unknown, it seems to me to be premature to recommend that Congress mandate that all states develop extensive programs to prevent elder abuse. However, I think it is appropriate at this point for Congress to amend Title XX of the Social Security Act to provide encouragement to the states to set up services which would treat and prevent elder abuse. That could be done by changing the reimbursement program from 75% federal dollars to 90% federal dollars. In that way, states would not be mandated to set up these programs but certainly there would be a financial encouragement for them to do so.

These are not intended to be extensive recommendations by any means but I think they are reasonable at this time. Before closing, I would like to submit to the record the written statements of two authorities on elder abuse who are unable to be here today. First, the statement of Dr. Suzanne Steinmetz of the University of Delaware and testimony of Dr. Marilyn R. Block and Dr. Jan Sinnott of the University of Maryland.

Thank you very much.

[The prepared statements of Dr. Steinmetz, Dr. Block, and Dr. Sinnott follow:]

PREPARED STATEMENT OF SUZANNE K. STEINMETZ, PH.D., UNIVERSITY OF DELAWARE, COLLEGE OF HUMAN RESOURCES, INDIVIDUAL AND FAMILY STUDIES

A 74-year-old-widow who broke her arm in a fall is invited to move into her son and daughter-in-law's home, only to find she is confined to a basement. Anytime she tries to come upstairs, her daughter-in-law physically forces her back down, often severely twisting her healing arm.

An invalid with an amputated foot, has a son that has been involved in a lot of trouble, and had violent episodes. She has called the State Police and signed a warrant but could not show up in court because of her condition. The son now has a gun and is threatening her.

In a drunken rage a middle-aged man beats his 67-year-old step-mother into unconsciousness with a metal pitcher. Admitted to the hospital where she is to stay for a month, she requires transfusion, multiple suturing of lacerations, numerous X-rays, orthopedic and neurosurgical attention.

We know from our studies of child abuse and wife beating that sensational cases while attracting public attention represents a very small proportion of the total abuse in the family. We recoil in horror over the story of the child who has had boiling water thrown on him or the infant who had lighted cigarettes pushed into his body. Yet we regard with complacency most of the estimated two million cases of severe physical violence which children suffer each year, child abuse in which the violence is less dramatic. However, we also know from newspaper accounts that, spanking often turns into a beating, or a slap which turns into a punch. Yet these instances of normal acceptable violence towards a child represents the majority of child abuse incidents.

As a society we seem to be more concerned with the visible outcome, the extent of injury received in a particular incident, rather than the act itself. We are moved to action when the slapping produces visible bodily injury but not concerned with the slapping itself. The same phenomena is likely to happen in the study of the battered elder. The newspaper headlines have been sensational. This may be necessary to draw our attention to the problem. However, it is important that future efforts look at the whole range of problems which make up the problem of the battered elderly individual.

My concern with this problem is the battering which takes place in generationally inverse families: those families in which the elderly parent is dependent on the child generation for emotional, financial, physical or mental support. In these families it is not just role reversal, but the entire set of generationally linked rights, responsibilities, and obligations which are reversed.

Discussing the sensational acts of abuse against elderly, holds our public attention but allows us to overlook the problems which occurs in our own backyards. Thus we recoil in horror from newspaper accounts of abuse against the elderly, and yet feel quite complacent about the less dramatic behaviors. By selective inattention, we have chosen as a society to ignore the problems which face the elderly population. While we have expressed concern over providing adequate financial resources, we've not looked at the specific interpersonal relationships which influence their perception of happiness and well-being.

There are several parallels between the battered child and the battered parent. By understanding some of these parallels, perhaps we can extend our knowledge about the battering child and the family and by this mechanism gain some insights into families where the parent is being battered. First, in both of these families, the victim is in a dependent position, relying on his/her caretakers for basic survival needs. Second, in American society we assume that one of the major roles of the family is to provide an environment for its members characterized by gentleness, loving, caring and emotional support. Finally, both the dependent child and the dependent elderly adult are often seen as sources of emotional, physical and financial stress to the caretaker. While the cost of caring for one's children are at least a recognized burden and are provided for in direct grants, public schooling, and tax deductions, the emotional and economics responsibility for the care of one's elderly parents over a prolonged period of time has not yet been fully acknowledged.

Often when we talk about problems occurring within the family it is very easy for individuals to suggest that in the past the family took care of their elderly. It is important then to put this problem in a historical perspective.

First, it must be recognized that life expectancy has increased tremendously. Thus, we have a larger number of people reaching the vulnerable elderly stage (75 years or older) than have occurred in any other historical period.

Second, we have for the first time a large number of people who are living beyond their economically productive years. Economically productive is defined in contemporary society as maintaining full time paid employment. With retirement coming between the ages of 60 and 65 (although it is extended to age 70), an increasing number of people now face a decade or so in which they are forced to live on fixed incomes. However, it is not just the income level which is reduced. Since the major identity in our society is one's work role, these individuals lose status, power and the prestige that goes with being an economically productive member of society.

Third, the advent of antibiotics in the early 1940's and major medical advances in the 50's, 60's and 70's has resulted in a large number of people living to old age in a physically deteriorating condition. In the past, survival of the fittest was a reality. Even such a common day occurrence as the flu was likely to be the death knell for any but the sturdiest elderly individuals.

If we examine demographic patterns, we become aware that the old expression "go West young men, go West" was, in reality, the pattern followed by generation after generation. First, there were settlers from Europe who emigrated to the Eastern shores and then each succeeding generation continued the move westward. We know that the three generational family, which has been held as the model and exemplified in the television series, The Waltons, was for the most part not the prevailing pattern of residency. It existed for only a brief period of time among families with large agricultural holdings. Obviously, those who moved were the young and healthy, the elderly stayed at home.

Thus, any three generational pattern found was likely to be for very brief periods of time when the young married couple was building their own home or when the elderly individual had moved in to die. Thus, for the first time in history, we have a large number of elderly people in a dependent situation relying on their kin for *prolonged* physical, emotional and financial aid.

While the examples opening my statement certainly are dramatic and suggest the need for immediate intervention, the kinds of physical and emotional abuse which most elderly people are experiencing is not as severe. Yet it must be addressed if we are to prevent many of these families from deteriorating into potential abusive settings.

We need to provide a mechanism for supply resources to families who assume the care of elderly persons. The government recently has taken the stance of "let families do it." While the best place for an elderly person to live may be with their kin, there has to be a recognition that without some additional resources, the prolonged and severe type of dependency which may result is more than the family alone can cope with. We need to also recognize that this family may consist of a couple (or individual) who is not only responsible for their own children and grandchildren, but are likely to be in the process of making plans for their own impending retirement.

The type of resources needed are such things as extending the meals on wheels service, providing homemakers, respite care, day care and financial help to cover the additional expenses required. There may be modifications or renovations needed in the housing, there may be special hospital beds, walkers and hospital type equipment required in order to care for the elderly person.

Education plays a very important part in this process. Few of us have had either informal experience in the care of the elderly person or formalized course work on this topic. Thus, the decision to assume the responsibility for an elderly person is often made devoid of knowledge of the tremendous amounts of responsibilities that will be required. While most of us embark upon the rearing of a newborn infant with at least minimal information on day to day care, such as diapering and feeding, most of us have no information on the care of the frail elderly individual with their special dietary needs and physical requirements.

In addition to education is the need for providing counseling to families who are responsible for an elderly person. Very often the adolescent parent conflicts of 40 years earlier have still not been resolved and the impetus for the child to leave home is because of these unresolved conflicts. We also know that in many families the only contact is the obligatory *Christmas or Easter visit during* which relations are strained and filled with guilt, resentment, and tension. Given this background, it is easy to understand the emotions which the adult child feels when faced with the realization of assuming responsibility for this parent.

Even if the relationship was a positive one throughout these years, the inversing of the generations and the ensuing responsibilities and obligations this entails very often needs some third party type of medication. It is difficult, especially if the older person is a woman, to realize that she is not the head of this household and that she really has no legitimate right to order her daughter to do things her way. At the same time the daughter who may feel ambiguity about her role as a child vs. her role as a caretaker, needs to have some support in setting down certain family guidelines. This is necessary to avoid the disruption of family harmony. This counseling helps both parties to understand their new role relationship.

For example, the daughter who has never been able to please her mother may find the mother's comments about her cooking being tasteless more than she can bear. Yet if she realizes that because of the aging process and the decline of the sensitivity of the tastebuds, the food may indeed be quite tasteless to mother. The older person will also need some help in understanding that the family needs some time to itself, that she cannot be the center of attention, and that her demands may have to be secondary to those of the family's.

There needs to be support groups set up for the middle age children who have the responsibility of caring for the elderly individual. Very often this decision is made in the atmosphere of guilt "my obligation to my parent." A rational discussion of present family responsibilities and how well they can be met if the elderly person moves in must be considered. Because of the cultural ideal of providing care for one's parents at all cost because of love, honor, and respect there is a reluctance to express the frustration and trapped feeling that a couple or an individual who is responsible for an elderly person feels. Somehow it is not socially acceptable to mention that you resent the amount of financial, physical and emotional drain on the resources that is encumbered when one assumes the responsibility for an elderly parent. If there were support groups where people could share not only their common problems but also the mechanisms used for resolving these problems this would help alleviate some of the guilt that is expressed by individuals who are in this caretaking position.

While the severe abuse and neglect that has often headlined in the papers is estimated to be somewhere around 10 percent of the vulnerable elderly who are in a dependent relationship. The numbers are probably much larger if we include the potential abuse and the stress and frustrations experienced by both the caretaking family and the elderly person. It is important then, if we wish to prevent the kinds of problems we have seen in child abuse and spouse abuse, that we start recognizing what will be required to reduce the stress on the caretaking families and provide them with the mechanisms for making this a positive experience.

We need to recognize that the population of people 65 and older is growing, that the cost of living is increasing and that there is a greater demand for alternative housing for the elderly. In sum, there just is not enough housing at an affordable price for elderly people who are unable to live totally independently. With the higher cost of living, a greater percentage of income will be needed to cover the basic necessities, and thus a smaller amount will be available for those things that we might call luxuries: additional cars, vacation, single family homes with ¼ acre lots, etc.

How this is going to impact on the family caring for an elderly person is not known, but one can predict that the smaller the amount of money available for luxuries, the smaller amount of money there will be to provide elder sitters or housekeepers or some of the other resources which might alleviate some of the stress. The final thing that needs to be considered is that the working woman is a growing phenomena. In many instances, women are returning to work after their children have left the home to meet some of the additional expenses to maintain the standard of living they have enjoyed. We find in some cases women are faced with situations of "if I work, who will take care of mother?", and yet if they don't work how can they meet their monthly bills?

With increasing conflict between the needs of parents and the goals of their children, we can predict an increase in the amount of violence children use to control their elderly parents unless adequate support systems are available.

PREPARED STATEMENT OF MARILYN R. BLOCK, DIRECTOR, AND JAN D. SINNOTT, ASSOCIATE DIRECTOR, PROJECT ON THE BATTERED ELDER SYNDROME, CENTER ON AGING, UNIVERSITY OF MARYLAND

Violence in the family setting, when considered at all, is usually viewed as an abnormality. The family is often conceptualized as a haven, a place to escape the stresses of the outside world. The definition of family as a source of love and gentleness implies that violent exchanges occur rarely in that setting. As a result, much of the violence which occurs in the family has been overlooked. Yet violence between family members is a common phenomenon.

The situation of caring for an elderly parent over a prolonged period of time has not been faced by most American families in the past. The responsibilities of such care have not been recognized as a possible burden in the way that childbearing has. Over the past several years, however, practitioners and researchers alike have come to recognize a social phenomenon which has been referred to by various descriptors, among them "granny-bashing" and "gramslamming." Despite the various labels, the grim truth is that there is increasing evidence that middle-aged adult children are physically and psychologically abusing their aging parents in a manner analogous to child abuse. Situations where the older person is victimized by family members will, in all probability, increase as greater numbers of parents live into old age and require care from their children.

INCIDENCE OF ELDER ABUSE

There are no statistics to document the scope of parental abuse by adult children, since these data have not previously been collected in any systematic manner. An article in the Cleveland Plain Dealer (March 5, 1978) noted that various professionals, such as social workers, gerontologists, and nurses, believe the problem to be widespread and not isolated to any race. Ohio attorney general William J. Brown has appointed a task force to study domestic violence and has gone on record indicating his belief that victims of elder abuse number in the tens of thousands.

The State of Connecticut recently passed an elderly protective service law (July 1977). In the eight months that this program has been operational (June 1978–January 1979), the office charged with administering the law has received over 600 reports. Some of them are still pending action, but of the 474 cases which have been activated, 87 were physical abuse, 314 were neglect, 65 were exploitation, and 8 were abandonment. According to State ombudsman Jacqueline Walker, many cases involve abuse and exploitation by children whose purpose is to force their parents to sign over property and money.

In Maryland, the Baltimore City Police Department reports 149 assaults against individuals aged 60 or over during 1978. Of these, 93 (62.7%) were committed by relatives other than spouses. They do not identify relationship to victim or type of assualt. The Baltimore County Police Department reports 87 assaults against individuals aged 60 or over for April–December 1978.

NATURE OF ELDER ABUSE

Isolated descriptions of abuse form the bulk of the information concerning the nature of the abuse that adult children inflict on their aging parents. Extremely little research has been carried out. Abused elders generally suffer from more than one form of abuse. The majority of descriptive cases reported by various sources involve both physical abuse and psychological abuse. Other forms of abuse include theft or misuse of money or property, forced departure from the family home, and forced entry into a nursing home.

Physical abuse is not necessarily in the form of severe beatings. The abuse may amount to no more than a shove, a slap, or a shaking, incidents that are minor when inflicted on a younger person, but are quite harmful to an older person.

Both prescription and over-the-counter drugs offer another source of potential abuse of older persons, who are often encouraged by their families to take large doses. Older persons may be given excessive amounts of sleeping pills or tranquilizers to make them more manageable. The various interactions of drugs may create confusion in the older person, resulting in unusual behaviors which may cause the child to increase the number or amount of drugs administered, resulting in a never-ending cycle of drug abuse.

Other forms of abuse have the intent of keeping the older person from interfering with one's plans for the day. The older person who needs supervision may be tied to a bed or chair so that daily activities can be carried out. Other forms go beyond the intent of keeping the older person out of the way. Parents are battered with fists or other objects to make them obey commands, or force them into financial decisions that they might not make of their own free will.

CHARACTERISTICS OF THE ABUSED ELDER

There is extremely limited information describing abused older persons. Those who have some form of impairment may be more likely to be abused. A study of elder abuse in Cleveland found that over three-fourths of the victims had at least one major physical or mental impairment (Lau and Kosberg, 1978).

Older persons tend to deny that abuse has taken place, which is one reason that the battered elder syndrome is so difficult to document. They may fear being removed from the family setting even more than the abuse itself. Refusal to report incidents of abuse to authorities may also stem from the fear of retaliation, the shame of admitting to such treatment by their own children, or the lack of alternative living arrangements.

POTENTIAL CAUSES OF ABUSE

The problem of elderly abuse has many dimensions, and information concerning these dimensions is rare. How the various factors interact to create specific situations of abuse will only be discovered through further intensive research efforts.

A hastily-made decision to have the aging parent come to live in the adult child's home may create the setting for eventual abuse. Such a decision may be reached quickly at a time when the emotions of the family are high. Possibilities for the parent to continue to care for him- or herself in an independent living situation may not be explored carefully.

When the older person lives in the adult child's home, a variety of patterns may create the setting for abuse. Increasing disability of the aging parent may interfere with what had been a happy relationship with other family members. The family may have felt forced into taking in the older parent or relative who could no longer live alone. The family may already have a high level of stress which could create violence whether or not the older parent resided in the home; the parent may then become the target of abuse even though he/she was not the initial cause of stress and tension. The presence of an aging parent may drain financial resources, limiting the spending pattern of the children to a large degree.

The older person may sense family tension and react by trying to prove that vitality has not been lost. He may attempt to engage in tasks that he no longer has the ability to perform, thus creating more interference and tension.

Power conflicts may develop between the older person and other family members. Children may have decreased living space and freedom of activity within their home. There may be conflict between the aged mother and the middle-aged daughter or daughter-in-law over household procedures and child-rearing practices.

Although the actual causes of elder abuse can only be determined after research is completed, a number of parallels between the battered child and the battered elder are evident. Both are dependent on the caretaker for basic survival needs. Both reside in a family setting that is assumed to provide love and caring protection. Both are sources of emotional, physical, and financial stress to the caretaker.

Our current research, funded by the Administration on Aging, is designed to assess the extent of the problem of elder abuse and to develop partial answers to the question "Why does elder abuse occur?" We also are attempting to develop models which describe different types of maltreatment of older persons and which clearly delineate the situational and personal factors involved. A fourth goal is to develop three approaches suitable for obtaining data on abuse and to compare those approaches in terms of feasibility, adequacy, cost, and usefulness for policy and program development. This data will come from agencies which service the elderly, from a selected sample of professionals, and from a sample of older individuals living in the community. Analysis of this information is now underway. It should provide direction to those who must deal directly with the elder suffering abuse.

Mr. DRINAN. Thank you very much, Mr. Bergman, for a very fine presentation. The next speaker will be Helen O'Malley, Researcher and Planner for LRSE.

STATEMENT OF HELEN O'MALLEY, RESEARCH/PLANNER, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LRSE)

Mrs. O'MALLEY. Good morning. My name is Helen O'Malley and I am on the staff of the Legal Research and Services for the Elderly. Legal Research has been funded by the Massachusetts Department of Elder Affairs to study elder abuse. As part of that study, we were responsible for conducting a statewide survey of professionals and paraprofessionals who we thought might have seen elder abuse over the past 18 months. That survey was conducted in March and April of this year. I'd like to describe that survey and present you with some of the findings that we think may be important in helping us understand and recognize these cases. I also have a copy of the survey which I'd like to enter into the record of this briefing.

(See appendix 1, p. 47 for survey.)

In our survey, we defined abuse as "willful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or deprivation by a caretaker of services which are necessary to maintain the physical or mental health of the elder." We defined elder to be anyone 60 years of age or older, living at home either alone or with family or friends. Clearly, we were not looking at institutional abuse which is something that receives attention now. We were looking for something even more hidden—abuse in the home. Also, as you can see from the definition, we gave abuse a rather broad meaning. We included some aspects of what most people would call neglect. We did specify, however, that the neglect or deprivation of services had to be willful in nature. What we were looking for were older people who were deliberately hurt in their homes by someone else.

We sent out over 1,000 surveys to medical people, social services professionals and paraprofessionals. We were trying to find out five things: who sees elder abuse, what are some characteristics of abused persons, what does the abuser look like, what injuries were sustained and what was done about it. When we analyzed the surveys returned to us, we found that 183 reported a citing of elder abuse in the past

18 months. That doesn't mean that we uncovered 183 individual cases of elder abuse because two or more people could have been reporting on the same case. But, certainly we found that a sizable number of people were seeing or hearing about abuse or suspecting abuse. Before I go on and present our findings to you I'd like to explain some of the limitations of this kind of survey. The survey was designed to give us descriptive information only. We didn't use random sampling techniques; we have potentially duplicated cases, as I mentioned. That means that anything we uncovered through this survey has to be validated by additional research. Let me give you our findings.

First, we found that almost every profession we surveyed has come into contact with elder abuse or suspected elder abuse. Visiting nurses, Home Care Corporation staff, hospital social services directors and home health aide staff accounted for most of the citings. Certainly, as we begin to construct our systems for identifying elder abuse, these professions should play key roles in identifying potential cases.

Perhaps one of our most important findings was that abuse tended to happen again and again to the same person. In 70% of the citings, abuse occurred more than twice and in an additional 8% of the citings, the abuse occurred at least twice. While our survey doesn't permit us to estimate the incidents of abuse, demographic trends towards an increasingly larger elder population and our findings on the recurrent nature of abuse, make it likely that we'll be seeing more rather than less of this problem in coming years.

Who's being abused? We found that abuse occurred in all age groups from 60 to 80 and over. But the 75 and over age groups seemed to account for more of the citings than we would normally expect. We also found that women tended to be victims of abuse more often than men in all age categories. This held true even when we controlled for the proportionately greater number of women than men in the elder population. 80% of the 183 survey citings said the victim was female. Looking at these findings on age and sex, we can begin to form a picture of the abused elder as someone who is likely to be quite old and who is likely to be a woman. We also found in ¾ of the citings that the abused person had some physical or mental disability that prevented him or her from meeting daily needs. We found that in 75% of the citings, the victim lived with the abuser and that in over 80% of the citings, the abuser was a relative. As one of our staff people said, "It looks as if abuse, like charity, begins at home." The data seemed to indicate that disabled or frail elderly who live at home with their relatives are prime targets for abuse.

The survey also told us something about the abuser. Almost ¾ of the survey said the abuser was experiencing some kind of stress such as alcoholism, drug addiction, a medical problem or a long term financial problem. The elderly victim was often cited as a source of stress to the abuser, primarily because the elder required a great deal of physical and emotional care from the abuser or was financially dependent on the abuser.

These findings of stress experienced by the abuser and the levels of disability of the victim are important because they give us some feeling for the factors that may be at work in the abusive situation. We know from studies on child abuse that abusing tends to occur in families that are under a great deal of stress. At least there's some indication that this is so. Is it possible that stress can be a factor in elder abuse as well? Does the stress of caring for an aging or disabled parent sometimes become so great that abuse occurs? Our survey certainly cannot answer that question but the high percentages of both disability and stress uncovered by the survey indicate that we should look a lot more closely at those two factors in future research and as we try to deal with this form of abuse.

We were interested in finding out what the abuse looked like to see if there were any physical signs that doctors or other professionals could begin to look for as they were dealing with these cases. We found that in most of the citings, the elder suffered some form of physical trauma, such as bruises, welts, sprains or fractures. Most of the trauma was minor in nature from a medical point of view, but some major traumas did occur, including fractures. Other types of abuse were described such as verbal harassment, malnutrition, financial mismanagement, unreasonable confinement, oversedation and sexual abuse. But, certainly, the great majority of citings were primarily situations in which the elder was physically battered in some way.

We also asked questions in the survey about how suspected abuse had been uncovered and what had been done about it. We found that the abuse had usually been brought to the attention of the person answering the survey by someone other than the victim or relative of the victim—70 percent of the abuse citings involved a third party as the reporter of abuse. Interestingly, one of the chief barriers to service provisions that respondents cited was this same unwillingness of the victim to admit that abuse had occurred or to accept services or help in dealing with the problem. Fear of retribution, our inability to protect the elder from further abuse and the shame and guilt which elders feel in discussing this problem make it very difficult for workers to deal with this kind of case.

Finally, we found that a wide variety of intervention strategies were used by respondents. Some respondents chose to confront the abuser and arranged no follow-up or back-up services after the confrontation. Others called in multi-disciplinary protective service teams to provide services for the victim, the abuser and the family. The survey doesn't permit us to assess the appropriateness of these interventions but it clearly points out the disparity among respondents in the skills and services which are being brought to bear in cases of elder abuse. Most workers try to deal with the problem when they see it but few systems are in place to help them manage these very difficult cases. Some of the other speakers this morning will discuss ways in which we can begin addressing the problem of elder abuse, whether through reporting laws or developing emergency housing facilities or formation of adult protective services teams. What I hope I can leave you with today is some sense of the serious nature of the problem which I think the survey helps demonstrate and the need for all of us to start being more aware of abuse as a potential problem facing the elderly. Thank you.

Dr. Mahoney. Thank you very much Mrs. O'Malley. As this question evolves in my mind, I'm wondering if you feel that the definition used in the survey might be such a broad definition of abuse that it could possibly increase or inflate the findings.

Mrs. O'Malley. I think that is quite likely. We did put something in the definition called deprivation of services or "neglect" which is not quite the same as "physical abuse." But we did try to limit the definition somewhat by specifying that the neglect had to be willful in nature.

To check on the number of actual batterings, we went through our surveys and looked at the section where we asked people to write a brief description of the abuse. In well over half of those surveys, the problem was what appeared to be willful battering of the older person. In only 30 of the 183 citings was verbal harassment or financial mismanagement the main problem. So I think that even though our definition is broad, we did capture reports that primarily describe physical abuse. I also think that in initial studies of this nature, a broad definition is useful in helping us see what is going on out in the world. We found very serious problems and we did find, in at least half of the citings, physical battering.

Dr. Mahoney. Is there any indication in the survey that the people who engage in child abuse or spouse abuse are also likely to commit elder abuse?

Mrs. O'Malley. Not from our survey. We tried to ask that question but I think the question was phrased improperly and we just couldn't understand the findings that we were getting. There are other people, such as Suzanne Steinmetz, whom Jim Bergman mentioned before, who are doing research on other forms of family violence and there does seem to be some indication that different kinds of violence can be going on in the same family. Also, that violence can be passed on from one generation to another. If you are an adult and as a child you were battered, you are likely to batter as an adult. In families where child abuse is going on, the child is much more likely to strike at a parent than in families where no abuse is going on.

Dr. Mahoney. Something close to that. I could not quite decode from the findings the percentage of people who abuse who have a personal problem. Would you say overwhelmingly that the people who abuse do, in fact, have a problem in almost all instances?

Mrs. O'Malley. I remember that figure, I think it was about 63 percent of those abusers had some kind of stress related problem according to the person who was filling out the survey. Some of those problems were alcoholism, drug addiction, loss of job, long term financial problems, even lack of education.

I think we really need to look at those findings much more carefully. Some studies, for example, have shown that alcoholism is one determinant of violence. But what about things like illness in the family or continuing financial problems? We need to look at that more closely.

Dr. Mahoney. Well, I have a question that occurred to me. Why is it that blood ties to the abused seem to be closely related to abuse here?

Mrs. O'Malley. I think that's an interesting question. We're not sure of its relationship to abuse. Abuse may have much more to do with living arrangements. In the survey, we found that yes, relatives were abusers, but we also found that those abusers were *living with* the victim. It may be that living with an older person, having to take care of that person, is the primary factor rather than relationships, in explaining abuse. In this society, certainly in the people we surveyed, the relatives happened to be the ones taking care of the victim.

Dr. **Mahoney**. Well, another thing comes to mind. Did the people who completed the survey find that there were other problems in dealing with abuse besides the unwillingness of the abused to testify or seek help?

Mrs. **O'Malley**. Yes, the people who filled out the survey did say that they were confronted with other kinds of problems: two basic problems, both of which I think were hit on in Brian's testimony. One is the problem of *access*, getting through that door, feeling that they have no legal responsibility or right to intervene in an abusive situation unless they have a complaining witness and we know that older people sometimes are afraid or unwilling to complain. That's the first kind of problem. The second one that the people who filled out the survey cited was the lack of certain kinds of services they felt they could have used. In many of the surveys, the people said they had to place the abused person in a hospital or nursing home when they would rather have used some kind of temporary housing facility or emergency housing facility for that person until the abuse situation could be worked through. In Massachusetts, we do have shelters for abused women and their children. Most of these, however, aren't set up to deal with the disabled elder person. You have to be ambulatory to get into those shelters and that's a real problem.

Dr. **Mahoney**. There are really programs for battered spouses.

Mrs. **O'Malley**. That's right. So we don't have shelters for older people that would provide some kind of care for them until the abuser can receive some counseling or until the emergency is past and long term plans can be made. As a result, people end up temporarily or perhaps permanently in nursing homes when it might not be appropriate.

Dr. **Mahoney**. This might be an area where the Congressman and his Committee could help us. Obviously, we would need funding for such a center on a pilot basis and that's a thing that would be well worthwhile.

Mr. **Drinan**. Thank you very much, Mrs. O'Malley, and we will proceed to hear Dr. Thomas Mahoney, the secretary of the Massachusetts Elder Affairs. He said that he's given his speech, he doesn't have to give another. Let us move on then. Next we will hear from Mr. Brian Langdon, the director of the Family Service Association of Greater Lawrence. Mr. Langdon.

STATEMENT OF BRIAN LANGDON, DIRECTOR, FAMILY SERVICES ASSOCIATION OF GREATER LAWRENCE, MASS.

Mr. **Langdon**. Thank you. My name is Brian Langdon and I am Executive Director of the Family Service Association of Greater Lawrence. My agency and two other family service agencies in the Merrimack Valley, Family Service of Lowell and Children's Aid and Family Society of Haverhill, together have a jointly funded project to provide protective and counselling services for elderly in the Merrimack Valley. This specialized program is funded by Title 3 under the Older American's Act and reaches frail, elderly persons who are suspected to be in a situation that is dangerous physically and/or psychologically to them.

About one half of the referrals that come to our project come from visiting nurses, public health nurses. About one-quarter of the referrals come from the Merrimack Valley Elder Service which is our Home Care Corp. in the Merrimack Valley. The remainder of the referrals come from landlords, neighbors, from counsels on aging and other social agencies. During the 12 month period from March 1, 1978 when we began this project until the end of February 1979, there were 82 cases referred to the program. The clients ranged in age from 60 years old to 99 years old and about one half between ages 80 and 99. Looking at one-quarter of the last quarter of the first year, we served 50 active cases during that three month period from December 1978 until the end of February 1979. Of those 50 cases, 8 were suspected of abuse by a family member, 4 were suspected of being physically abused by a nonrelative and 3 were referred for possible neglect by family in caring for physically dependent elders. However, once we got out into assessing those 50 cases, the clinical social workers assigned to the protective and counselling services project found in their own follow-up that of the 50 cases, 21 were experiencing harm or were seriously threatened with harm by the actions of other individuals upon whom they were dependent. In many of these cases, the primary reason for referral had not been suspected abuse and neglect but rather had been for reasons of confused or disoriented behavior of the elderly person which someone had observed for poor housing or because the referral source felt there was a need for more supportive services to the elder and the elder was resistant or the family was resistant to accept that.

Physical and emotional abuse of elderly persons is sometimes, we find, very, very difficult to document. Pleas for help or disclosures are frequently later denied by the elderly themselves. Physical and emotional dependence and fears of retaliation by caretakers are important factors, certainly. Many elderly persons fear separation from their home and familiar surroundings. Because of this, they resist telling outsiders what may be really happening. In other instances, the older person's family is resistant to any community intervention. The family or the important caretakers for the older person will block intervention by such tactics as threatening legal suits for trespassing on their property. Protective services programs for elderly do not have a clear mandated authority as to programs for children to investigate and follow-up on suspected abuse or neglect. Staffs on elderly programs are in a very gray and foggy area when it comes to intervening in these kinds of situations.

Causes for abuse and neglect of elderly people by their families seems to us to fall into several broad categories. First, are those families where their emotional, physical and even financial resources are depleted in their efforts to care for frail, elderly persons. In these situations, the elderly person may be confined to bed at home, confused, incompetent, wandering at night. Most of these families have been fairly well adjusted and have a strong sense of obligation to care for their elderly family members at home. These are families that if you met them, you would believe they had a very strong sense of commitment to their own. But the burden has become too much and the family is overwhelmed. They are caught in a conflict of the values. Second are the families where past, unresolved family conflicts become reactivated during the stress of caring for an elderly family member or where the elderly person's increased dependency needs lowers their own abilities to protect themselves from longstanding anger and resentment of another family member. Frequently, in such instances the older person's financial resources are abused. Sibling's battle over property and the older person does not get the services and help which, in many of these instances, he or she certainly needs and to which he/she may be eligible and often can afford.

Third, are those families which have long histories of poor adjustment in the community. Frequently, these situations involve a very emotionally disturbed family with paranoid family members and usually the family member who is caring for the elderly relative is themself very disturbed. They are suspicious of other people and remain isolated from neighbors and others in the community. They angrily and directly reject any outside help and usually deny any need for assistance at all.

The fourth category involves those elderly who are victims of abuse or neglect because of the failure of the community to provide sufficient support and help to their families. These are families that are really victims in a situation that any of us could find ourselves. These situations include elderly persons needing custodial care who are discharged home from acute care hospitals because nursing home beds are not available.

It involves families where homemaker, home health aide services are needed but not available several hours a day, seven days a week. It includes older persons who need a limited guardianship or conservatorship and cannot afford such services.

I'd like to share with you briefly four case examples which I think document this type of abuse and neglect. First, a 94-year-old lady lived alone with her son whom she had cared for all his life. Her husband died 25 years ago and except for an elderly cousin in Canada, there is no other living family. They have managed to take care of themselves successfully until three months ago when Mrs. G. fell and hurt her back and was hospitalized. After one week in the hospital, she was discharged home. She was unable to walk. She stayed in bed and her son tried to take care of her and feed her. He would heat soup and provide meals that way. The landlord discovered that the son was unable to care really adequately for his mother when he came to collect the rent. He called the Protective Services Program. Fearful of separation from his mother again, the son resisted at first efforts to help. But he was amenable to the trusting relationship of the claim caseworker who carefully and very thoughtfully approached the situation. But the greatest resistance to providing help to this 94-year-old lady was the resistance of the hospital to accept her return back into the hospital. It was necessary for her to return to the hospital because there was no other alternative for her care in this community. The hospital said she needed custodial care and was not an acute care patient. They did finally admit her only after a social worker, a visiting nurse and an attorney accompanied her by ambulance to the hospital and threatened to call the newspapers. The neglect in this case was a combination of the inability of a family member to provide care and a lack of appropriate discharge planning from the hospital. The limitations set up for categories and levels of medical care do not meet the special needs of individual families in a time of crisis. Neglect of elderly people can be the unintentional result of what had been a well functioning family.

Mrs. D. was 86 years old. Her situation was brought to the attention of our program by the director of the counselling agent who had received reports from neighbors that Mrs. D. had been seen wandering around the neighborhood in a confused state. This was during the winter. She was wearing her nightclothes and slippers with snow on the ground. On three occasions, she was observed walking up and down the street and seemed to be totally disoriented as to where she was going.

Mrs. D. had four sons. She owned a considerable amount of property in town. Two sons lived nearby and two lived out of state. The four brothers did not get along and could not come to any agreement about a plan for her care. The two that were most available undermined constantly each other's efforts to help and accused each other of attempting to pilfer her estate. The social worker was able to get the brothers to accept a plan for a few hours—only a few hours—of home health aide services weekly. But Mrs. D. in actuality needed 24 hour a day care either at home where she could have afforded it or in a nursing home. She died six months later without the adequate services that she had needed.

Mrs. M. is 68 years old. She was widowed one year ago. She has three sons and one daughter. She is severely crippled with arthritis and has a heart condition. One of her sons was serving a sentence at Walpole Prison when her husband died. He is a heroin addict and when he was paroled, he moved into her apartment. He was angry that he had not been properly notified about the death of his father and blamed his mother for that. He was verbally abusive to her, stole money from her, stole a television from her and stole a stereo which her husband had bought on time and was his prized possession. She was referred by the visiting nurse after Mrs. M. disclosed to the nurse her fear of her son. The protective services worker was able to help Mrs. M. through the parole officer to get the son to move out. However, she could not bring herself to press charges against her son or in any way to try to reclaim any of the property which he had taken from her. With the help of legal services, she was cleared of her responsibility for debts which he had incurred on her charge account. But it took two months of work with her to get her to deal with the embarrassment and feeling of shame that she had about the whole issue of indebtedness that he had incurred and her good name. She felt, was being tainted by not paying her bills.

The last one I want to share with you is a case involving a woman named Miss C. who was 76 years old. Her only relatives are a nephew and his wife with whom she has almost no contact. She is a very passive and dependent person who has been this way all her life. She has lived alone for the past six years since the death of her sister with whom she has lived for many, many years. She was referred by a visiting nurse on the basis of her own complaint to the visiting nurse that her conservator was stealing from her. Miss C. is unable to handle her financial affairs. She receives the vast amount of $335 per month in combined social security and supplemental security income. The conservator handles her bills and helps her with grocery and other shopping. The fee which this attorney, who is her conservator, charges for these services is $100 a month. This appears to be a somewhat usual charge, a minimal charge perhaps for such services. Assessment of Miss C.'s complaints revealed that, indeed, her complaints of abuse are realistic. She is unwilling, however, to change her situation. She is frightened, she does not know who else will take care of these kinds of tasks. Indeed, until there is some form of resource such as a guardianship corporation, we have no alternative to be able to provide the kind of service which this attorney does provide, constant shopping, handling of the bills, paperwork, that kind of thing. This kind of abuse results when there are no other alternatives in the community and when the client is really dependent and fears any effort to move in the direction of being more independent.

I thank you for the opportunity of being able to share some of our observations about what we see as an increasingly troubled problem of abuse and neglect.

Mr. DRINAN. Thank you, Mr. Langdon. If I may, I have a couple of questions for you and then I have a couple of questions going back to Mrs. O'Malley's testimony. Going through your cases, my mind keeps raising the question: What legal arrangement could have prevented this or helped it? Take, for instance, the case of the 86 year old woman with four sons who could not agree on a plan. What legal remedy could have helped?

Mr. LANGDON. Well, in that instance, I think, for an agency or somebody to have authority to even be able to get into a situation. This one was fortunate in that we were able to get in because we were able to provide the counseling over enough period of time to the son who was the closest, living next door, to even let us into the house. He had thrown out a case manager from Elderly Services who had tried to go in. He had threatened legal action if anybody went through the door. So, first of all, I think there is the need to have the authority as with Protective Services for Children, that when there is an abuse or neglect situation reported, that somebody actually can investigate it.

Mr. DRINAN. Would you suggest that the Massachusetts law needs to be amended to permit entry into a home to investigate suspected abuse of an elderly person?

Mr. LANGDON. Yes, but with the caution that the rights of privacy of people, and the sanctity of the family be respected. Such a law, I think, would require highly skilled people on the staff who understand the dynamics of families and the issues of families.

Mr. DRINAN. But what other legal arrangement or legal amendment would you be suggesting as a result of your findings?

Mr. LANGDON. Certainly, the need for a Guardianship Corporation in this state as a legal entity which can provide guardianship to low income and indigent persons who need as much of that kind of service and frequently need it more than those who are more affluent. If you are affluent you can secure the aid of proper persons to manage your affairs. Another legal change that we see certainly is the need for limited guardianship and conservatorship. In some of the cases which I did not use here, we have found that people often secure conservators or guardians during a period of stress or crisis, often when they go into a hospital, and, following discharge from the hospital. But people change, they grow, they get better and it's very difficult unless you're an extremely sophisticated person to change that legal status. People do not always need a guardian who takes care of all of the responsibilities in their life.

Mr. **Drinan.** Do you have any particular proposals about alterations in federal regulations or federal law that would assist in some of these situations?

Mr. **Langdon.** I think that in the federal law, perhaps, the most important thing is to support states in getting funding to help us to begin to develop programs. I certainly would support and encourage any efforts to allow us opportunity for demonstration projects and programs where we can do some of this pioneer work.

Mr. **Drinan.** Well, one last question and perhaps Dr. Mahoney will have some questions, but my mind also raises the question whether this is neglect or whether this passes over the line and becomes abuse. In these instances, I would think this is neglect but are we prepared to say this is intentional abuse.

Mr. **Langdon.** I see very little need to differentiate between abuse and neglect. I think as with children, neglect becomes abuse. Neglect is the first step to more serious physical abuse. In some instances, what is happening is people could be considered emotionally or psychologically abused. Our experience has been different than the research indicated in terms of physical abuse and battering. Now, I don't know if this is the result of having not been strictly a medical kind of program. We have seen, by far, abuse in terms of the kind of harassment that happens to people, and deprivation of entitlement. But, we have not seen the extensive kind of abuse that was cited in the recent project with bruises being one of the most primary symptoms.

Mr. **Drinan.** Thank you, Mr. Langdon. Our next witness will be Meredith Savage, the Regional Ombudsman of the Connecticut Department on Aging.

STATEMENT OF MEREDITH SAVAGE, REGIONAL OMBUDSMAN, DEPARTMENT ON AGING, STATE OF CONNECTICUT

Ms. **Savage.** Thank you. My name is Meredith Savage, I am the Regional Ombudsman for Eastern Connecticut. From the other cases I have heard today, we're all pretty much running into the same type of problems. I would like to tell you that under Connecticut law we are required to investigate any complaint alleging abuse, neglect, exploitation or abandonment of any citizen age 60 or over. In my particular area, I am in East Sturbridge which is rather rural, we cover 56 towns. We have another piece of legislation to investigate the same types of complaints stemming from nursing homes. So, we have a pretty broad spectrum with which to deal with. Probably one of the most interesting cases, and I say interesting because it is about the worst case I think I have had, happened to be my first case. This happened February 1, 1978 and to compound my agony, Jackie Wilson, my boss was out of town. But I want to relate it because another point I want to bring out is we use four categories and in many, many cases we cannot use just one. In other words, the case we are going to talk about involved physical abuse, neglect, and exploitation. We are finding this in more and more cases. What we hear from the family is that we love Mama and we will never put her in one of those nursing homes. But the translation is Mama owns the farm and if we put her in one of those nursing homes, there goes the money. I think that's something we should all be particularly aware of.

In this particular instance, our department of social services called me stating that a mentally retarded young man had told his social worker that his grandmother was being physically abused. This is all we had to go on and the worker said we don't know how good this information is. With that, I paid a call on the lady and took a legal services person with me because the social services in our state was not involved in the program so I got a legal assistance person to go.

We located the woman off in the country and attempted to get in. Her daughter met us, there was nothing wrong with Mama and so forth and so on. Finally, we talked our way in. I said I was from the State Department, an agent and part of my job was to offer services to an elderly person. The daughter's husband heard the word "state" and finally let us in.

I walked into what I think is one of the worst situations I have ever seen. It was basically a two room shack. There were no inside walls. There were just outside boards, no insulation, no sheet rock, nothing. There was a kitchen with a cold water tap. Then, a fairly large room contained an elderly woman, 86 years old, her daughter and son-in-law, the daughter's teenage children and my client's two mentally retarded grandsons along with her son. Along with this, I counted something in the vicinity of 20 to 25 cats and dogs. They, believe me, were everywhere. They were crawling in and out of the sink, on the food, back onto the floor and so forth. There was a cold water tap. My elderly client was there. She was 86 years old. She was in a metal chair restrained by a chain. I got to talking to the daughter on the basis of why do you use that type of restraint? A nurse taught me, she said. If I use cloth she's going to rip it. Her mother also had black eyes which I picked up on immediately.

We could elicit no information from our client. She had been judged senile by a physician and was pending conservatorship. She could do nothing but curse and babble the entire time we were there. The only heating place, and this was in February, was a wood stove. There were also birds in cages. The son-in-law became very vocal and made it abundantly clear that he wove the carpeting. This is basically a chicken coop on an acre of land but it's in a good rural area where the land is worth money, probably about $12,000.

I assessed very quickly what was going on and the next day met with the chief of police and the probate judge. Because our law was so very uneven, the chief of police invoked the cruelty to persons statute, stating that he can get in any time there is reason to believe there is abuse. So the chief of police, a sergeant and myself went back to the home with the neighbors standing by outside. The couple was gone but there was a mentally retarded boy at home. Reluctantly he let us in. At that point my client was in a little ante room on a filthy, rotten bed, with a dirty mattress. There was a tremendous stench of urine, and vermin were climbing on the walls, and so forth. Within 20 seconds the police chief said she's going and ordered the woman moved from the premises. At that point I noticed my client had a second black eye.

We immediately went to the hospital and the police chief ordered a 72-hour period of observation. Obviously, this was for the protection of the client. We thought that we had the case pretty well under control, until we had been at the hospital for a time and in came the daughter and son-in-law. The son-in-law is well known to be violent. He is also known to be armed most of the time, and has been in prison for attempted murder. He threatened to murder the detective that was with me. On this particular day he was carrying a pair of scissors which made me nervous. We had been in the emergency room and were told she could be moved from there. She was totally incoherent. Her son-in-law said you cannot do this, "I am going in and I am taking her." So, of course, the hospital called the police. But, before the police could get there, the staff removed her from the emergency room and literally hid her on a ward where the son-in-law could not find her. He then threatened me at that point so the staff hid me in the kitchen until the police arrived.

The upshot of this case is that two other agencies had been in that home. When we started breaking it down we learned that between the client, the mentally retarded child, and the dependent children, about $650 a month tax free money was going into this home, plus the son-in-law worked. In the end, the probate judge conserved the woman and we immediately got two doctors. The probate chief named the chief administrative officer of the town her conservator for 30 days. That gave us time to have the woman examined to see what her physical needs were. It was obvious she had to be placed in a nursing home which the conservator could order.

The couple was charged with cruelty, but I don't think they were ever prosecuted. The mentally retarded boy was placed in the home as were the minor children. The minor children were returned some two months later, I believe.

Again, that is one of the worst cases we have ever had. I think it certainly points out that we have a problem. I don't think any of us realize the enormity of it until we really started getting into it. What we're finding is that the more and more people who are aware of the protective services for the elderly, the more and more phone calls we're getting. We have a string of mandated reports very similar to that used for child abuse. Again, the more that the public becomes familiar, the more and more calls we're getting.

Another case that I think is extremely interesting involves a call I received about a woman left alone in this house in Waterville. I did a little digging and I found that she had been living with a companion for some 20 years. He had been struck by a car and was hospitalized. I paid a call on this lady and it became obvious that she couldn't help me at all. This woman knew nothing except her name, Dorothy. She did not know how old she was. She couldn't even read or write. When I went into the apartment, I could smell within 20 feet of the door it was really bad news. There were open cans of food all over the floor.

She would put the stove on in case she wanted to cook and she couldn't remember if it was on or off. She appeared to be severely retarded.

It was one of those situations in which we could not leave her. She couldn't cook and the place was so filthy it was evident she couldn't remain alone. So another avenue that we can use sometimes, which we used this time, involved contacting the health director of the town. He went with me back to this apartment. Because the condition was so bad that the floors were literally rotting because of filth, he condemned the apartment on the spot. We finally talked to Dorothy and explained she could not stay. The health director then had to place her in Orange Hospital which is a psychiatric facility because there was no other place to put her. This is a situation that turned out well because I referred it immediately to social services and through digging came up with a birth certificate and her full name. She had no income of any kind and was entitled to Social Security. She responded well at the hospital. They even taught her to print her name. So things are going well. The plan is that her companion will be out of the nursing home soon and hopefully can get them back together. It's the only relative type person she has.

That's just another example of the way that we handle the broad spectrum of problems that we get. Lastly, there is the ongoing problem. For example, my friend, Mr. C., lives on the street or in his car. He refuses to live in a house. His hand had been injured, and when I met him it took something like 3 days to get the police involved. Finally, we got a service station attendant to sign a complaint that he was trespassing so we could treat the guy. Later he broke his hip. He is now in a nursing home but he will be back living on the street soon. He is judged competent. So this is what we've been working with for years. That about sums it up. Thank you.

Mr. **Drinan**. Thank you very much, Ms. Savage. If there aren't questions, we will proceed to Meg Harari who is a caseworker for the Family Services Association.

STATEMENT OF MEG HARARI, CASEWORKER, FAMILY SERVICE ASSOCIATION OF GREATER BOSTON, MASSACHUSETTS

Ms. **Harari**. Thank you. My name is Meg Harari, Unit Supervisor, Family Service Association of Greater Boston, Service for Older People. Our unit provides counselling, advocacy and outreach to frail elderly who, because of physical and mental handicaps, are not able to deal with the problems of daily living and have no one to help them. Through counselling and delineation of resources we can help an elderly client remain in his own home.

The majority of clients we see suffer from impaired judgment, poor physical health and lack of knowledge about resources. A small percentage of our clients, about 1 percent, are particularly high risk because of physical and mental abuse. This is the most difficult kind of situation to work with because the abused elderly person is often physically and emotionally dependent on the abuser, who as we've seen, is usually a member of the family. The abuser is a son or grandson, occasionally a daughter and in a few instances, a husband or wife. The abuser tends to be an alcoholic, a drug addict or a person with a history of mental illness. The abuser rarely is receiving any kind of social service. A typical case is Mrs. X who is 76 years old, physically handicapped, using a walker.

Mrs. X lives with a 34-year-old grandson who has a history of drug addiction and alcoholism. He is separated from his wife and children whom he abused. Mrs. X was not bound by her grandson. He stole all her money and food and walked out on her. She was referred to us by home care after a report from her homemaker was filed. Mrs. X was given additional homemaker service and financial help. Contact was made with her family and the name on her bank accounts were changed. A week later, the grandson called and Mrs. X welcomed him back, denying that he was anything but an exemplary grandson. It may take months to work out a better life for Mrs. X until she can accept a plan where she is assured the kind of care she needs without being so dependent on the grandson. The worker will also attempt to involve the grandson in counselling and set up liens against his maltreatment of his grandmother.

In cases where the elderly person does not complain, the presence of the worker cannot be a deterrent against further abuse. Working with this kind of situation requires long term involvement. Abuse tends to be the product of social isolation, lack of treatment for mental illness, addictive conditions and disturbed family functions. We do not find abuse among elderly in housing projects or elderly who are an integral part of the standard family system.

Another example that illustrates these points is Mrs. A., age 75. The abuser was her husband who was 70 years old. They married when she was 69. Her health declined and she gradually became senile. Mr. A. worked all day as a cook and left his wife alone in a tiny basement room crawling with insects although with their combined income they could have afforded a good housing situation. Left alone without adequate food or supervision, she had frequent accidents with multiple fractures and was repeatedly hospitalized. She was placed in the nursing home but moved against medical advice by her husband. They had no family or friends. Mr. A. had a gun and was threatening everyone who would keep his wife from him. A family service worker worked extensively with Mr. A. about alternatives in caring for his wife. Better housing was offered. However, Mr. A. wasn't cooperative. When Mrs. A. was later hospitalized, Mr. A. again wanted her back home. The hospital finally instituted temporary guardianship and later permanent guardianship procedures. Mr. A. was brought to court and our witness testified about the home situation. The court ruled that the hospital could assume guardianship and that Mrs. A. be placed in a nursing home. She has since done very well and appears more mentally alert.

One of the major difficulties we found in working with the abused elderly is the lack of resources in a non-protective living environment. Mrs. K., a 75 year old widow lived with her 42 year old son who was diagnosed as schizophrenic. He threatened her and all the neighbors with bodily harm. Mrs. K. felt shame as a result of his public behavior. Mrs. K. developed very high blood pressure, was not only afraid of what would happen to him if she left but of what would happen to herself if she stayed. She went through the courts which kept her son in jail one night but they released him for family counseling which he refused. The mental health clinic refused to take any action. With counseling, Mrs. K. learned to set some rules for behavior which did improve the situation somewhat. She applied for senior citizen housing but had very low priority because she was currently living in a subsidized family housing situation. With social work intervention, Mrs. K. was accepted in senior housing as protection from her son's abuse. At first the son was barred from visiting Mrs. K. But finally, he learned to behave and comes to see his mother peacefully. He is now receiving services at a mental health clinic. Mrs. K. sees the the social worker for counseling and emotional support.

There are numerous questions about elderly abuse. Tragically, we find that the situations where we intervene have gone on for a long time. The abused older person does usually not complain and we find the situation frequently by chance. Social intervention is a long and difficult process. We are pleased to see better laws but frustrated at how rarely abused people use their legal rights. Elderly abuse tends to be systematic with general lack of social services for the elderly. We feel that a concerted effort in this direction is an integral step in reducing abuse. But, with additional social resources, abuse can be uncovered soon and more elderly protected. Thank you.

Dr. MAHONEY. Thank you very much, Ms. Harari. May I just question this. You and others have suggested that this is just the tip of the iceberg and I'm not certain that the evidence supports that. Other people suggest that senior elder abuse may be increasing and I don't see evidence to support that. Would you talk about that point?

Ms. HARARI. Well, the incidents appear low. About 1 percent of our clients have been abused as such. But we are concerned that we are only seeing the tip of the iceberg as someone put it before. With more publicity, we may uncover more cases, many more cases. We are concerned that elder abuse, whether mental or physical, is a life threatening situation. We feel that through proper social service intervention, lives can be saved. Lastly, we feel that intervention for the abuser can rehabilitate him at the same time.

Dr. MAHONEY. But, would you agree that as far as I read the survey and other information such as it is and it's in very, very short supply, that we shouldn't generalize and say that it's increasing or it's much more widespread than we know?

Ms. HARARI. According to the cases in our agency, this is something that's been occurring in recent years.

Dr. MAHONEY. Well, if I heard you correctly, you said that you didn't have any record of abuse in housing projects. I think, goes totally against that. Certainly, in urban housing projects there have been gangs terrorizing elderly, snatching handbags from elderly people, inflicting violence on them and this has been going on for a few years.

Ms. HARARI. In our survey, we found that in the housing projects with safe supervision and good locks on the doors, there hasn't been any.

Mr. DRINAN. If I may interject here, the House Select Committee on Aging has held hearings on crime against the elderly and it is very, very shocking that there are, as Dr. Mahoney says, gangs. That's a separate problem, however. We are not talking about that. That is not neglect or abuse of the elderly. That is just old-fashioned crime against the elderly.

We thank you very much, for your presentation. We move now to a new panel, issues in treating cases of elderly abuse. The first witness is Mr. Howard Segars who is a psychologist for Legal Research and Services for the Elderly.

STATEMENT OF HOWARD SEGARS, PSYCHOLOGIST, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LRSE)

Mr. **Segars**. Thank you. My name is Howard Segars. I am the staff psychologist with Legal Research and Services for Elderly. I've worked with the abuse project since it began in February of this year. As part of that job, I helped with development of the state-wide survey and co-developed the training sessions which were conducted in five project sites in Massachusetts. As part of the preparation for those sessions, I spent several weeks reading the current literature about abuse against spouses, domestic violence against children as well as the little information that seems to be available in terms of instances of abuse directed against older people. In addition to that, I spent some time talking with a variety of professionals, people in ministry, people in social work, people in medicine and nursing, about their experiences.

Before I came to this job I, too, worked in a protective services unit and one which had a somewhat different case load than that of Ms. Harari. My staff and I worked in poor city neighborhoods, exclusively with older residents. During all of this experience, I've worked with hundreds of people who I think, by and large, are really dedicated, sincere individuals. I've seen sometimes staggering sums of money allocated in the community and yet I cannot say that I've seen a great deal of change taking place in terms of the serious problems affecting those elderly people whom I would consider abused. I hope that the testimony today will have something to do with framing some more adequate, realistic responses that will truly address these themes.

Personally, I have regarded the horror story testimony with some suspicion. But I am equally wary of the sort of theorizing which gets detached from what all of us experience on a day to day basis when we walk into our clients' houses. My own research has indicated that while there may be a gas shortage, the last thing this country faces is the shortage of theoretical social service response models; they are everywhere. However, I want to talk about what we are going to do tomorrow and the day after, what we are going to do that will actually help in a tangible way. I am hopeful that people will not get lost, that the clients will not get misplaced in facts and figures and citations of the law and these academic discussions of theoretical models. I have to confess that as a part of our work, we, too, have come up with 8 different models of abuse. In order to be serious, it seems, a problem has to generate theoretical debate. Or, perhaps the issue of violence against those who are vulnerable, those who are elderly and infirm, so horrifies us that we treat the problem theoretically.

Basic to the discussion of these cases is something very simple. You have to be able to differentiate an emergency case from a non-emergency case. I would like to offer two examples that help make that distinction. First, let us consider for a moment what a caseworker can do when she is confronted with an 80 year old woman barred from her apartment at 7 in the morning by her sometimes abusive, but more frequently hallucinatory, brother. The man is 10 years the client's junior, and he has provided some support services for her over the past few years. The client is dressed in her nightclothes; she's frightened; she's ashamed and at this point, this vulnerable point, she enters a fragmented protective services system as an emergency case.

Let us examine what that system can do. It can provide intensive and, I think, generally high quality counseling of a problem oriented nature. That service can be in place in an hour or two. So can an alternative source of food through a Title VII site, if the money lasts to the end of the fiscal year. An emergency referral can be made to Legal Services, though in my experience a person in this kind of situation is less likely to consider legal remedies and usually not a legal remedy against a family member whom she knows to be disabled. All of these programs fall into "emergency services" or "crisis intervention." The danger inherent in approaches like this are ones that our survey tend to bear out. Abuse, more often than not, is a repeated occurrence. If you treat each of these episodes as acute periods in a person's life, you are treating it as if it is some self-contained unit; a violent period in a person's life that is somehow detached from everything else that goes on. I think that's self-defeating from a professionally critical point of view and it is counterproductive from a management point of view.

If we content ourselves for a moment with an emergency response, let us consider that there may be a problem of housing for this client while she tries to make up her mind about what to do next. Emergency shelters have time limits. Psychotic brothers don't. Emergency shelters rarely have provisions for those who suffer from the infirmities associated with aging. Nursing homes do. All too often in this kind of case, ongoing care for a client is going to mean premature institutionalization. This means premature death and this is what I want to talk about. When the cure is perceived as worse than the disease, it is small wonder that those who need help are reluctant to avail themselves of it. Old people are by and large just that; they're old, but they are not stupid. Almost 30 percent of those victims reported in our survey who refused services, refused them, I believe, because they knew the likelihood of options open to them. They refused services because the services were limited and they were perceived as threatening as the conditions the clients were already experiencing.

Emergency cases, such as the one I have described, generally fall into the more restrictive category of programming. For all the discussion and for all the writing about least restrictive alternatives (which has become a talisman for my profession and many others) the whole thing is academic if those least restrictive alternatives don't exist. You can talk about them, you can write about them, you can develop 8 different kinds of abuse response models which utilize them, but if there isn't money to pay for them, who really cares? That is why there are emergencies. There aren't the alternatives that are supposed to exist. On the other hand, and I hope the more fortunate one, it's good to look at a case that was programmed non-emergency and I think prevented nursing home placement through good case management.

In this case, the client was an immigrant woman in her late 70's who had enjoyed a pretty active life until visual problems and a few other minor infirmities made it difficult for her to live alone; not impossible, but difficult. At that point, she accepted a middle-aged niece's invitation to live with her and share expenses. The niece, it soon became apparent, however, was a troubled person who was really unable to provide many, if any of the services, she had offered. The caretaker/niece began not only to cash but to misappropriate her aunt's checks. Worse, she locked up all the food in the house and starved the woman as well. The story emerged in a curious way. First, the client told a friend who herself was elderly. That person participated in a recreation center through a Title VII nutrition program. She told the recreation worker. The recreation worker in the Title VII nutrition site in turn told a protective services worker who brought it to my attention because I was administrator of the grant. The aunt had reason, I think, to use that kind of round-about way of asking for help.

On one occasion her niece had begun deportation proceedings against her and she constantly threatened her aunt with nursing home placement. The worker assigned could have investigated the case and simply offered the same nursing home option as the niece, treating the case as an emergency and not as part of a possible longer term solution. Instead, she realized her client's desire to remain outside an institution, a desire so strong that the aunt was willing to risk staying in an almost certainly abusive situation rather than accepting temporary placement in a nursing home which generally means long term, if not life-time placement. While the elderly woman stayed with her niece for another two months, the protective service worker was able to maintain counseling while referring the niece—who repeatedly refused even to discuss these issues—to Social Security for an investigation of the alleged misappropriation.

Social Security was very useful there. This allowed the client to regain control of her funds, something which she had always been able to do but this was something that the niece had simply taken away from her. Once the client had an income, no matter how limited it was, it was possible for the worker to begin looking for housing. At that time, the Commonwealth had enough money in this region to offer homemaker services so the minimal services which had previously been offered by the niece could be covered. Her new living arrangement was near a Title VII nutrition site so she had food and companionship if she chose to avail herself of those services.

I maintain that if this case had been treated as an emergency, if the client had only been offered a nursing home placement instead of some less restrictive alternative, if there had not been money for homemaker services which made the move into independent housing possible, she wouldn't be alive today. Either the effects of slow starvation at the hands of the niece or involuntary institutionalization would ultimately have proved lethal.

I am concerned that we not forget that people die through programmatic failures. The Rose Institute Study shows conclusively that for people who experience involuntary institutionalization, 20–40% of them are dead within 6 months. Now, there are a lot of ways to look at those statistics and I hope we do not get into a debate of what they mean. It does indicate, however, whether 20% or 2%, some people are dead as a result of this manipulation and that I find reprehensible.

For me, these are only two of a much larger body of cases which I personally have witnessed. I have repeatedly seen middle aged children threatening their parents with nursing home placement, for whatever reason, whether it is to gain control of resources or simply to relieve themselves of the tedious task of care. I have seen people overmedicated because physicians have said, "when your mother starts to act up, give her two more of these ." If two are good, four more are better and six more is best. These are daily occurrences for all of us who have worked in the field. There is no need for this. All of us are going to get old. Many of us are going to find exactly the same things happening in our own families. Ignoring this kind of problem will hurt us all. I truly hope that because of this testimony, because of the workshops this afternoon, we are going to be able to begin making some changes. They do not have to be that costly. But they do have to be coordinated. Thank you.

Mr. **Drinan**. Thank you very much. If I may, may I suggest that you spell out the changes that you're calling for—first at the federal level. Would you have some specifics that you would recommend the Congress follow?

Mr. **Segars**. I would like to see, as Jim Bergman pointed out this morning, some incentive given through Title XX perhaps, not only to develop different kinds of services but to reward those states and those communities which coordinate services. I, for example, administered a half million dollar adult protective services grant which was programmed through the Department of Public Welfare, but which depended for most of its support services on the Department of Elder Affairs. There's no linkage between those two. It would not cost money to have people sit down occasionally and say there are x number of cases here, there are x number of dollars there, you do this and this and this. We'll do these other things.

Mr. **Drinan**. Would you suggest anything that could be done about emergency shelters?

Mr. **Segars**. I think that there should be emergency shelters. But I think first we have got to track some cases and set up a system which will allow that to happen. Once you have got that base to work from, you can figure out where the centers should be located. I have gone beyond the point where I have to be convinced that shelters need to exist. Personally, I already believe that. I am not certain where they have to exist. I don't know what they should look like, and I don't know how they should be staffed. I do know that there are people available on the Department of Elder Affairs staff and in private agencies who can answer those questions. I know that you can use computers to track cases if you have got a reporting law and find out in a relatively short period of time how to develop shelters and how to do it in a way that is responsible.

Mr. **Drinan**. Would you say there is a consensus among all the knowledgeable people in this area that we should have emergency shelters?

Mr. SEGARS. I think not only for elderly people but for disabled people, for people who are being returned to the community.

Mr. DRINAN. Well that is another but this is a new dimension.

Mr. SEGARS. Certainly, without question.

STATEMENT OF RUSS MORAN, DIRECTOR, ELDER SERVICES OF MERRIMACK VALLEY, INC., MASS.

Mr. MORAN. Thank you, Congressman, Dr. Mahoney, ladies and gentlemen. My name is Russ Moran, I am Executive Director of Elder Services in Merrimack Valley and I would like to thank you for the opportunity to address this critical problem affecting all the people who have been abused and neglected.

The problem is real and needs immediate attention. With the increasing number of older people and the increasing pressures, tensions and frustrations of today's society, the older person becomes an extremely vulnerable target. I would like to limit my response to some of the concerns that have become evident since the protective service program began in the Merrimack Valley about 18 months ago.

The services are delivered by a consortium of three family service agencies acting to provide intervention and support. Approximately 25 percent of all the referrals to the program are made because of the extensive abuse by a family member or other person. Most often, the abuse appears to have developed over many years and often family members see a need for this kind of action. The program then confronts two problems. One is resolving the immediate crisis or problem and the other is attempting to begin to work with the family over a long term basis. Neither solution is easy and often can be impossible.

As in child abuse, the older person is not always willing to recognize the problem because of fear of retribution or loss of security. Adult children or grandchildren are often themselves unable to see the problem and can be unwilling to accept community support. How the community responds, then, is critical. Police departments, emergency rooms, and mental health agencies must become aware first that the problem exists and then that something must be done together.

I again stress, as was stated by the previous speaker, the aspect of coordination: Services must be coordinated and delivered in a manner that does not jeopardize the outcome of the plan of care. Once the immediate crisis has been stabilized, long term support should be available to minimize the possibility of future problems. Such long term support can include counselling, specialized homemaker services and case management as well as informal support and I would stress informal support. Networks can be developed and can be made to be responsible, progress can be made despite barriers that exist.

I believe, however, that we are in reality providing a mandated approach. There is clearly a need for protective services. We must also begin, however, to move in the direction of intervention. We must know why the problem exists and what can be done to ensure that abuse of the elderly will be reduced and hopefully eliminated. Currently, the system of service delivery that we all operate under often encourages the problems that are being discussed here today. Because of inadequate funding, support services were only delivered to those elders in greatest need. This is true of Medicaid, Title XX and Title III funds. While this program is clearly necessary, it inappropriately assumes that old people are being served to the full extent of their needs. What happens, however, in reality, is that we only service those in the most desperate situations. This encourages people to become poorer and sicker before they receive services. In addition, since our focus is largely on locating isolated, elderly people, we often forget the outreach that must be done in families.

An article on aging and family by Elaine Brody at the Philadelphia Geriatric Center disputes the belief that many families are abandoning their parents. She states "the myth may express the guilt of a youth oriented society in need of a scapegoat for the general neglect of the old." If anything, the formal support systems of the family, friends and volunteers provide a wide range of care. Unfortunately, however, this informal support system often jeopardizes the delivery of formal supports. In a system that serves only the most desperate, social services are often terminated or not made available to people if there is family involvement or other informal support. This may be done because there is a choice of offering care to one who has no involvement or to an older person who does have family involvement. So again we continue to insure that older people will have to deteriorate further before we caregivers can help. The family who is blamed for abandoning their parents, but was actually involved in providing care could not get the support from the community, becomes resentful and frustrated. Thus the stage is set and the old person is a visible and vulnerable target in the system.

Obviously, there are other causes that may affect elder abuse. Families must have access to community agents. Policy makers and legislators have to begin looking at treating the entire family unit rather than just individual, isolated members. Categorical funding has to allow for some discretion in eligibility requirements. Funding levels have to be made realistic and cannot be used to create a future demand for services. In general, we must not only treat the symptom, we must also treat the underlying problems that cause the symptoms. I believe to succeed in this will take commitment at all levels of government. Protective services have been discussed for years and as an example, here in Massachusetts, protective service has been listed as part of the Title III state plan for elderly people for the past three years but has never been funded. This year they finally recognized that and removed it from the Title XX plan rather than put money into it. This is disturbing. The commitment must be made now because delay only jeopardizes the health and safety of many older people. It is time to stop talking and start doing. I respectfully ask for the full support of Congress and the state, and you can depend on our support. I would like to respond to one question you asked earlier, that of whether we can demonstrate today whether there's an increasing need. I am not sure we can demonstrate it today because we have not been given the resources to demonstrate that. The resources, as indicated earlier, have largely been patchwork. I think what Mr. Bergman mentioned earlier, research and demonstration grants have to be made available to truly demonstrate the magnitude of the problem and what are some of the causes. I think those are some of the things we can relate to you and we look forward to working with you and other members of the state and federal government.

Mr. **Drinan.** Well, thank you very much. May I ask this question which has not been brought up today. Is there a role for volunteers or community groups in this area?

Mr. **Moran.** Yes, I think a very critical role they can play, in meeting needs that were refused by formal support systems because of eligibility requirements or other barriers to service. They can provide long term support and have outreach into the community. This can be done by volunteers and other support groups. This is critical and has to be made part of this network. If I may relate an organization in my own congressional district in the Pittsburgh area, they monitor nursing homes and on a voluntary basis, they have done really extraordinary work. They are in the business of looking for a federal or state grant so they can have a part time or full time executive director who will just keep the correspondence and that type of thing.

Mr. **Drinan.** Would you see a need in the area of neglect or abuse of the elderly for such an organization?

Mr. **Moran.** Definitely. To help professional care givers who because of limited case loads or decreased funding can rely on the informal support of volunteers and family members and churches to play a very significant role in at least maintaining stability on a long term basis in a family situation and can help us monitor that situation as well.

Mr. **Drinan.** I was wondering where, since it has taken so long to discover child abuse and spouse abuse, do you think we are going to have to span the same number of years before we really get a good handle on this problem?

Mr. **Moran.** I hope not. I hope we would have learned some things from child abuse and spouse abuse. I think we have to be careful when we say we were discovering elder abuse. I do not want anyone to assume that this is just becoming a problem. The problem has existed, it is just that we did not know it before.

Mr. **Drinan.** Thank you very much. Now the next witness is Jacqueline Walker. She is the State Nursing Home Ombudsman for the State of Connecticut.

STATEMENT OF JACQUELINE WALKER, STATE NURSING HOME OMBUDSMAN, DEPARTMENT ON AGING, STATE OF CONNECTICUT

Ms. **Walker.** My name is Jacqueline Walker, I am the State Nursing Home Ombudsman with Connecticut's Department on Aging. I am here to testify on Connecticut's experience with abuse and neglect of the elderly. In July, 1977, Connecticut passed two important pieces of legislation dealing with the elderly. One bill was the establishment of the nursing home office, an office within the Department on Aging. The other was a reporting law for the protection of the elderly. That has to do with any person sixty years or older, anywhere in the state, institutionalized or otherwise. It is concerning this bill that I wish to testify.

At the time this piece of legislation was introduced to the legislature for passage, the Department on Aging was unable to uncover any definitive statistics concerning the number of elderly persons who had been abused or neglected in this state. We made inquiries at hospitals, emergency rooms, police and family social agencies but none could produce statistical information. Fortunately, however, the legislation passed both the house and the senate with no problem.

This success was due in part to the effort put forth by Representative William Ratchford, former Commissioner on Aging and Chairman of the Governor's Blue Ribbon Committee To Investigate the Nursing Home Industry in Connecticut. The office is funded with $250,000 which covers the salary of the staff as well as the operating expenses of the ombudsmen. The staff is comprised of a state owned ombudsman and five regional ombudsmen who work out of the five home planning and service areas of the state.

The ombudsmen are responsible for receiving and resolving nursing home complaints and problems presented to them by family, friends, patients and nursing home administrators and which concern the lifestyle and care of the patients in nursing homes, rest homes and homes for the aged. The program went into effect upon passage of the legislation July 1, 1977. The protective services program went into effect the following January of 1978 and I would, before I go on, just like to interject that between January, 1978 and June, we really downplayed the program for the simple reason that we were waiting for the regulations to be passed. We did not want to go ahead without the regulations so that the number of cases that were produced between January and June are negligible.

It was from June even though the statistics I will read you later will view the entire period. That program utilizes two state agencies and functions in the following manner. Mandatory reporters consisting of primarily professional people such as nurses, physicians, police, social workers, ministers, etc. are required to report suspected or known cases of abuse, neglect, abandonment and exploitation of elderly persons sixty years of age and older to the office. They may report the case either to the state or to one of the five regional offices. After receiving the report, the ombudsman is required to make an immediate investigation and assessment of the problem. This requires a personal interview with the client as well as contact with as many involved agencies and family members as are available.

Once the decision has been made by the ombudsman that indeed there is evidence of neglect, abuse, etc. he discusses the problem and possible solution with the client. He suggests a course of action, including types of protective services which would benefit the client in his or her present circumstances. If the client agrees to this assistance, the ombudsman than refers the problem to the elderly protective service unit within the department of human resources. The human resources is the new re-organization and it is social service or welfare but in our state they have now really messed it up. Each district office of the state department of human resources has within it a special unit called the elderly protective service unit. This unit consists of a supervisor, as well as at least one worker assigned specifically to that program.

On receipt of referral from the ombudsman, protective services visits the client, works up the case and makes provisions for those services to be provided. The type of services may include such things as homemaker, home health aide, public health nurse, hospitalization, conservatorship, financial management, counseling, and psychiatric evaluation. In those cases where a client refuses all the services which are offered, it is up to the ombudsman to make a determination as to the competency of the client.

Because the ombudsman spends a fair amount of time with each client, she, therefore, has the opportunity of utilizing such things as the mental status quotient as well as other methods of testing in order to ascertain whether or not in the ombudsman's judgment, the patient is capable of making decisions. If, in the judgment of the ombudsman, the client appears to be incompetent and thus is incapable of making a decision, the ombudsman than refers the case to the protective services worker and writes those findings along with the report. When the protective service worker follows up on the case, he/she will in turn make an additional judgment as to the competency of the client before any services are provided.

It is important to remember that the purpose of the program is not to interfere with the right of self determination of a person. Rather, it tries to provide services for a person who is in a dire situation and who can benefit from some type of intervention. Frequently the ombudsman and/or the protective services person are able to obtain a psychiatric evaluation of that client. There have been some instances where a client is fully competent and is suffering from a terminal disease, realizes that he/she has only a few months to live and simply does not want any help.

In instances such as these, we do not interfere. We allow those persons to make their own decisions and live and die as they choose. Our program has also developed a close relationship with the probate court system in Connecticut. At the time this program went into effect, another important piece of legislation was passed, namely an act concerning the appointment of conservators. The ombudsman as well as the protective service workers met with the probate judges in every town in Connecticut to discuss the responsibility which would be put on the probate judges with the onset of this bill.

This bill provides for the appointment of emergency or technical conservators, for those individuals requiring immediate attention. There have been many instances where we have used that vehicle. In some cases, the situations have involved immediate hospitalization or delivery of services to the home in order for the person to survive for a few days until medical attention could be obtained. Since the program has been in effect, there has been an overload of cases reported to our office. More cases than we ever anticipated and more serious than we ever anticipated. The ombudsmen have been astounded, sickened and shocked to see the severity of problems in situations which abound in the community. Problems which, until this time, have been unnoticed by agencies and community officials.

From January, 1978 through April, 1979, the total number of reported cases is 937 with a total number of problems associated with those cases 1,065. Of these reported problems, there have been 651 concerning neglect. Neglect includes both self-neglect, those elderly who have become incompetent to the extent that they were incapable of providing basic, necessary care for themselves as well as neglect by a caretaker. The caretaker being either a family member or the conservator or another person residing in the same home.

There have been 166 cases of physical abuse. From our statistics, a majority of abuse has been inflicted by either the grown children of the abusee or by a spouse. In spouse abuse, it has been primarily the husband who has abused the wife. In addition, there have been 127 cases of exploitation and 32 cases of abandonment. There were also 89 cases that we classified as other, meaning that persons were indeed needing some kind of assistance but technically did not fall under the categories of abuse, neglect, exploitation or abandoment.

As I indicated before, the ombudsmen have been astounded at the severity of the cases that have been running rampant in the community. Of the 169 towns in Connecticut, 107 have reported cases to date. All mandatory reports received packets with a brochure outlining their responsibility as well as the report forms. In addition, meetings have been held and are continuing to be held with social services agencies, hospitals, local and state police and citizens to more fully discuss the program and its implications.

In order to more fully emphasize the workings of the program and the types of cases that we receive, I would like to relate to you a few examples of cases which were taken from our files during the past year. Mr. and Mrs. A. live in an apartment over a store. The son, age 22, lives with them. They are the only tenants in the building. The son has been physically abusing the parents for many years. Usually following arguments over money. The son demands money and when his father refuses, the son beats him. The last incident was in March, 1979 between 10:00 p.m. and midnight. The mother was struck in the back with a frying pan and the father was clubbed with a stick. According to the parents, the son has been a problem since he was a child. He has had psychiatric help in the past. The parents have had him arrested only to be released by the police. The son told the parents that if they sent him to Connecticut Valley Psychiatric Hospital, that he would kill them when he got out. The son refuses to leave the apartment and the parents are terrified. They refuse to return to the apartment.

The father is a cardiac patient and a diabetic. He suffered a heart attack after the last incident of abuse. The recommendations by the ombudsman were that the son should not be allowed to remain in the community and that he needed psychiatric evaluation and possible placement in the state mental hospital. The parents feel he needs lifetime placement in a mental hospital. The parents will require a protective environment as well as counselling while arrangements for the son's care are being made. The report was made to the protective service unit as follows.

These two people arrived at the VA Hospital because of what had happened to them. The VA physician called the ombudsman who arrived on the scene where this history was taken. The result of this case was that the son had a psychiatric evaluation and was admitted to Connecticut Valley Hospital. There is some question as to what will happen if and when the son gets out. However, when a protective services unit took over the responsibility of this case, they agreed to follow this person for the entire time he is in the hospital. When and if the son is discharged from the hospital, they will receive a notice of his discharge and can then make the appropriate arrangements for protection of the parents.

I am going to skip the next case just to shorten this up and give you perhaps just the last one. This case concerns a woman who lives alone in a huge, decayed old house. She lived there with her father until he died three years ago. The women is obese with a lymphatic disease. Her left leg is extended to the point of elephantiasis. Below her knee where the infected condition existed, her foot is an inhuman looking mass of postules. At one point the flesh had eroded away and the bone is exposed. This person denies any problem with her leg. She wraps saran wrap around it to shrink it. The odor in the house is a putrid stench that permeates the clothes of anyone that enters the house. When her father died, a conservator was appointed since a great deal of money and property was left to her.

The conservator is a cousin who has very little to do with the client other than to pay her bills. The client is fairly lucid in most conversations, however, there are times when she seems to appear to be extremely confused. She has food delivered but has no working refrigerator. She uses only three rooms of the house and sleeps on a filthy, dirty, torn, stained couch. Her clothes were covered with blood and drainage from her foot. She refused any help but absolutely needed medical attention.

After referring this case to the protective services worker, the woman was finally taken to the hospital after the necessary action to accomplish this was taken care of by an order from a probate judge. She is now calm and cooperative and is receiving treatment at a hospital. There will possibly be a biopsy and subsequent amputation of her leg. She also has a large mass in her stomach and has been diagnosed by a psychiatrist as a schizophrenic. It is hopeful that when this client is finally released from the hospital that she will be able to go back to her home with proper assistance in terms of a homemaker, home health aide and certainly, a visiting nurse at least initially to assist her so that she can live a relatively normal life.

I have attempted to relate some cases which we consider to be typical of the problems received in our program every day. A day does not go by that each of the regional ombudsmen does not receive at least three reports of some kind concerning neglect, abuse or exploitation. The program is time consuming and keeps the ombudsman constantly on the go, especially when added to the nursing home problems which continue to come in as usual. We realize fully that as the program continues and as more and more people become cognizant of our work, we will be inundated with problems.

There is no question in our mind as to the importance of the program. We realize fully that there are endless numbers which are still hidden away waiting to be uncovered. From our brief experience, we can readily say that abuse and neglect are prevalent in all walks of life. There are equally as many problems in affluent neighborhoods as there are in poverty stricken areas, in rural as well as urban areas. The problems are found in all ethnic groups. Women over 75 were more frequently reported than any other age. This year, the ombudsman office anticipates that it will be able to do some research and analyze elderly injuries in order to document those injuries which can only be attributed to mistreatment and abuse rather than to accidents. This has been done for child abuse now so that there are definitive injuries for children that can no longer be attributed to accidents on the child's part but can definitely be attributed to abuse by parents. We are hoping, I am not sure we will come up with anything because we are dealing with a much different age group here, that maybe we will be able to come up with this kind of information.

In addition, we hope to investigate and analyze the abuser as well as the conditions which may encourage and invite abuse, such as is the abuser a former abused child? Does the abuse occur more often when the older person lives in the grown child's apartment or home? Or does it occur more often when the children live in the parent's home? This kind of thing I hope will give us some information. As yet, we have only touched the surface of the problem. Time will tell what the future holds for those of us who work with this type of program as well as for those of us who live to become one of the fortunate or unfortunate elderly citizens. Attached is a copy of Connecticut's Elderly Protection Service Law for your information as well as a brochure which was mailed to every mandatory reporter in the State.

[See appendix 2, p. 106 for material submitted by Ms. Walker.]

Ms. **Walker**. I would like to say one thing again in answer to one of your earlier questions in terms of what you think could be done by the federal government. I have very definite feelings about this.

First of all, our program which utilizes two agencies, namely the Department on Aging as well as the Department of Social Services which I will still call it, I think is extremely important. I think there is very little dialogue between state agencies and I think that is important. Second, I think that we have a state ombudsmen program which we developed because, to be perfectly honest, the federal ombudsmen programs which are nation-wide are not adequate. They are not viable programs. The funding is completely inadequate to run any kind of a program like that. My feeling is that most programs are designed and are carried out in this country for the convenience of the people running the program; not for the convenience of the people utilizing the program. My feeling is that a protective service program, if you have a viable ombudsmen program, which relates to nursing home and extended care facility problems, the public then knows them and hopefully that will be within a Department on Aging. I say that because it has been successful with us. The public knows then that it is the Department on Aging that you go to with that kind of an elderly problem. My feeling is the public is entitled to know that when there is a problem with the elderly in any fashion, they go to one agency, that they do not go here with this problem, there with that problem and somewhere else for some other problem; that a protective service program if it is developed, should be a cohesive program with the ombudsmen program so that the public knows they call one place when they have a problem with an elderly person in the community and they get a response. That would be my remark on that.

Mr. **Drinan**. Thank you very much, Mrs. Walker. I was very interested in this Connecticut law. Would you know if other states have such laws requiring mandatory reports?

Mrs. **Walker.** The only thing I can tell you and maybe Jim can do better at this than I, when we developed this in 1977, at that time there was only one other elderly protective service law which was in North Carolina. It did not utilize two departments. It came out of, I believe, the Department of Social Services. I do not know what has happened to it. I believe there are adult protective service laws in various states but I do not think they are elderly protective services.

Dr. **Mahoney.** What kind of funding are we talking about in your State; the one you spoke of?

Mrs. **Walker.** Well, to be perfectly honest, again that's a problem state-wide. The $250,000 which funds the ombudsmen office and consists of the state ombudsmen, five regional ombudsmen, typists and office expenses is what covers the protective service law in terms of our role in the law. Now, Title XX money has been used in the Department of Social Services to fund the elderly protective unit in that Department. Also, Title XX funds are used to provide services for those clients that use services in the protective service unit. I might add that even if we go to somebody who is extremely well off who needs services in this program, we do not bicker over who is going to pay. If they need to be extricated for a problem, the services are paid for, then we will discuss who pays and how it is paid for.

Mr. **Drinan.** That's a very fine testimony. Now, Mrs. Walker, one last question. It says in the law that any person required to report under the division of this section who fails to make such report, shall be fined not more than $500. I know that the law is new, but have any prosecutions been made under that particular law?

Mrs. **Walker.** No, because to be perfectly honest, although I will tell you that we fully intend to use that, we have not run up against an instance yet where we have found anybody who we feel has not reported when they should. But we fully intend to use it if we do.

Mr. **Drinan.** Thank you very much. The next witness is Karen Meyers, an attorney with the Legal Research and Services for the Elderly.

STATEMENT OF KAREN J. MEYERS, ATTORNEY, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY (LRSE)

Ms. **Meyers.** Thank you. My name is Karen Meyers. I am a staff attorney on the Elderly Abuse Project of Legal Research and Services for the Elderly. Over the past several months, I have conducted extensive research in the area of elderly abuse, focusing on the state of the law in Massachusetts, as well as nationwide. I have also conducted training sessions on this issue for social and legal service workers.

It is clear that any case of abuse is inextricably bound to the legal system. This is true whether one is looking at federal legislation, Title XX or state programs developed pursuant to welfare regulations, or, more specifically, when considering the remedies and procedures available to a client seeking service or to an agency seeking to provide involuntary services. Any case plan that is developed must be developed from a perspective that takes into consideration statutory and judicial alternatives.

Underlying these processes are the basic and fundamental issues of the civil rights and liberties of the individual. What stands out clearly in this consideration of the law is that the existing statutes and remedies are by and large inadequate: although predicated on the importance of utilizing the least restrictive alternative in treatment and placement, there is insufficient funding and development of programs and alternatives which would make this premise possible. For example, legal remedies and intervention procedures do not always include service provisions which provide protection of the physical welfare and constitutional rights of the individual. There is too frequently reliance on inappropriate intervention procedures and consequently, violation of constitutional standards because of our so-called desire to do what is "best" for the infirm elderly person and because of our justifiable horror and discomfort with the reality of abuse.

Potential abuse clients can be divided into two initial groups. The first are those individuals who are willing and eager to pursue, on their own initiative, a legal remedy or service provision. Secondly, there are individuals who cannot or do not seek assistance and enter the system through intervention procedures. In the first case, the abuse victim can seek recourse through criminal and civil remedies. But the civil process does not necessarily provide a viable alternative. Most likely, the elderly person is dependent, emotionally, financially or socially on the abuser/caretaker. In these cases, the elderly person would never consider filing a criminal complaint because he or she might not desire to. This alternative also fails to provide protection of a victim. The criminal process operates in isolation from any service provision. These services are the basic support systems essential to insure the welfare or potential self-efficiency of the individual.

Recent legislation has been passed in 24 states which establishes civil remedies and injunctive relief for victims of domestic physical abuse. Of these states, 17 have laws which include broad coverage provisions including the elderly person living with a relative or nonrelative caretaker. Although the provisions of the statutes vary from jurisdiction to jurisdiction, the majority include the issuance of protective orders, temporary restraining orders and vacate orders. The Massachusetts law, which I consider to be one of the best, includes a provision requiring police to take specific action to enforce these orders and to assure the safety of the abused person without requiring that that person return to court once the order has been violated.

This legislation can be a useful and potentially effective legal tool of protection. However, its usefulness is seriously limited in the case of the elderly. The elderly person is often unwilling, because of fear, intimidation or sickness, to file a complaint. The fact that most laws are not coupled with provision of supportive or protective services, or, if services are provided, they are not geared to the elderly, is another deterrent since the elderly person is often faced with the alternative of being left alone if the caretaker/abuser is removed from the home. Another limitation is that courts or police have been slow and reluctant to apply this law to the elderly person. The elderly person is often unable to assert his or her own rights if the order is violated. The need to return to court, repeatedly, in order to enforce a protective order can be unduly prohibitive in such a case. Nonetheless, these statutes do provide alternatives for some elderly persons.

One example of this is found in the case that was related by Mr. Bergman this morning, where the woman agreed to seek a temporary order as well as a vacate order after four months of social service intervention. It is important to note that this took place in an area which had an extensive protective service program in place. That program was able to provide the services which enabled that woman to go to court, take that risk, and be assured that she would have service provision after she was alleviated of the abuser/caretaker. In that situation the woman has been able to continue to live in the community.

Let me now turn to the more complex and difficult issues. As has been stated today, the elderly victim, who has been abused, exploited, neglected or abandoned is often infirm, confused and dependent. These individuals usually lack the physical or mental capacity or ability to seek or consent to assistance. States can act pursuant to legislative authorizations of Social Welfare, Public Health, Mental Health departments, and so on. But, the scope of this authorization is limited. Social services workers repeatedly raise the question of their rights to initiate investigations, to intervene in family matters and to seek court intervention. These issues raise the classic conflict between the right of the individual to privacy and self-determination in opposition to the power of the state to intervene where state interest in protecting the vulnerable person arises.

I would venture to speculate that a majority of those persons involved in this area of law and social services would agree that there are those cases which do require intervention by the state and we could probably agree that services should be provided to persons-in-need who are unable to consent to the provision of such services. But, let me speculate that there exists a great disparity among those same individuals when asked to consider what procedures and safeguards should be followed before the provision of involuntary services. Furthermore, disagreement would probably exist as to when such services should be provided and what kind of services should be provided.

Individual rights of self-determination and privacy are not absolute. The state can certainly regulate the parameters of those rights through the police power and parens patriae. But, in addressing these issues today, we cannot forget that basic to our legal system is the right and sanctity of the individual to have free choice and self-determination. This right extends to the elderly no less than to any other person in our society.

Attempts by different jurisdictions to meet the needs of the elderly have resulted in the adoption of abuse reporting and protective services laws. Presently, 11 states have laws which provide mandatory reporting of suspected cases of abuse, neglect or exploitation, access pursuant to court order to investigate reports and provide services, and provisions for involuntary intervention and service provisions in certain cases. The majority of these statutes do cover adults who are either the elderly, 60 and older, or specifically people who lack the ability to obtain services for themselves for disability reasons or whatever. Five states in addition have established statutorily mandated voluntary protective services. These states do not include the reporting provision or the intervention provision. An additional 2 states have adopted protective service legislation which includes involuntary service provisions but does not include mandatory reporting or investigation.

Of the laws that include involuntary services, a majority of them include provisions for hearings, assistance of counsel, the right to be present, and notice. But, shockingly enough, in these cases, where the issue is the deprivation of basic civil rights, there are 7 states which do not provide for due process of law. Persons deemed to be in need can be taken into custody and placed in a facility against their will "for their own protection," without a hearing, without counsel, and without adequate notice. In order to resolve this conflict between the state's interests and the individual's rights, without losing sight of either, legislation should minimally include the following provisions:

(1) The adherence to the principle of less restrictive alternative and self-determination.

(2) A mandatory reporting statute which is linked with investigative and service provisions.

(3) Prompt response of verification and assessment by the designated agency.

(4) Injunctive relief where caretaker intervenes in the investigation or provision of services.

(5) The right of the person who is deemed mentally capable to refuse services at will.

(6) Funding and development of least restrictive alternatives that make that premise a reality.

(7) Utilization of multi-disciplinary geriatric/clinical assessment teams in the provisions of servicing.

(8) Due process of law provisions including a hearing, adequate notice, right to be present at the hearing, the right to cross-examine parties represented and assistance of counsel prior to the hearing.

(9) Provisions for limited intervention, particularly in emergency cases.

(10) Provisions which enable flexible criteria to be used in order to reach all elderly persons in need and not just the very poor. And in all cases, the drafting and adopting of adult protective service provisions must be linked to the development of extensive services which emphasize alternatives to institutional care. Thank you.

Mr. DRINAN. Thank you very much, that's excellent testimony. May I ask just a couple of questions. Of the 11 states that have laws that require mandatory reporting, is Massachusetts one of them?

Ms. MEYERS. No.

Mr. DRINAN. Yet, the Massachusetts law is, as you suggested, is that a good law?

Ms. MEYERS. The Massachusetts law is good in terms of the abuse prevention law, that is, completely distinct from adult protective services or reporting. That is a law that requires the victim of abuse to utilize the court system themselves, it does not allow for any sort of intervention or outreach. It is a civil remedy for abuse victims to get injunctive relief.

Mr. DRINAN. Well, in what other respects is the Massachusetts law deficient?

Ms. **Meyers**. It doesn't have any legal provisions in Massachusetts to allow for social service workers to receive reports which assure immunity and confidentiality from persons in the community of abuse situations. It does not allow an agency to be designated to handle those kinds of reports. It does not have provisions which then require mandatory investigation and which allow for access where access is denied by a caretaker. At this point, social workers will go to a home on a basic outreach or report and they get there and the caretaker says, "Mom's fine." They have no legal recourse to do an investigation, to find out what's going on in there, without violating confidentiality, and rights of privacy.

Mr. **Drinan**. I wonder, has there been some model law proposed by some national group?

Ms. **Meyers**. Yes; there has been. There have been model laws, one of the model laws is presently active in North Carolina.

Mr. **Drinan**. Has the national group proposed a model law that states adopt?

Ms. **Meyers**. Yes, Legal Research and Services has proposed a preliminary one. We are in the process of proposing extensive recommendations that would be getting to the point of a model law to address all these issues. At this point, it is not completed. Other than that, no, there are not that many organizations that have taken a look at this issue.

Mr. **Drinan**. Well, I would suggest to Kathy Gardner on the staff of the Aging Committee that we might well consider putting out a study document on this and get the Library of Congress involved. We might propose a model law. The Commissioners on model laws are very, very expert in this area and they should be interested. Then a state could not say, oh, we have to do a lot of extensive research. They could just take the model law and then go to the Connecticut law and other laws and they would be ready for enactment, probably.

Ms. **Meyers**. I think that would be excellent.

Mr. **Drinan**. Thank you very much. The last witness of the morning is Thelma Bailey. She is the Associate Director of the New England Resource Center for Protective Services in Boston.

STATEMENT OF THELMA BAILEY, ASSOCIATE DIRECTOR, NEW ENGLAND RESOURCE CENTER FOR PROTECTIVE SERVICES, BOSTON, MASS.

Ms. **Bailey**. By now, everyone is good and tired, hungry, restless and I commend us all for sitting through the morning without changing the schedule. Now, I come to you as the social work professor and currently as co-director of the New England Resource Center for Protective Services which is one of the regional centers established through the National Center on Child Abuse and Neglect. After 30 years of practice as a social worker dealing with those services to the elderly and to children and families, I certainly feel like the historian of the group here.

I do need to correct some of the prior testimony that says that protective services for children is new. Some 102 years ago, Mary Allen, chained to her bed in New York, was found by a visitor, referred her to the American Humane Society who care for animals, the SPCA, because 102 years ago there was not protective services for children. However, at that point the national organization was pulled together. You, in Massachusetts have just celebrated your 100th anniversary of your SPCA and its director, Bob Mulford, just received our National Recognition as an outstanding contributor.

Then, in 1962, dragging their heels behind them, pushed by Henry Camp, the physicians joined us as he brought to our attention, battered children. Physicians in England had done it earlier. Then in 1973–74 the legal profession joined us in pushing the Mondale legislation and mandated reporting. Then, as most of us in this room become mandated reporters, we are finally all working together 102 years later. We have a long history. It must not take that long for us to get together in terms of protective services for the elderly. We now have mandated reporters for children's protective service. We know that we only see the tip of the iceberg. Referrals come to us only because someone gets into a house and sees. People are not let into houses where the elderly are tied up, sat down abruptly on their commodes when they need to go to the bathroom for the 10th time that day and somebody is disgusted with it. These things are unseen by outsiders. The reports we get are if somebody comes in. The moment we have mandated reporters, a physician who might notice some kind of red mark about the buttocks from being jammed down onto a toilet or commode will get reported because it's expected and some people may say, indeed there may be abuse.

Now, we have talked this morning about the difference between neglect and abuse. I could suggest that if the quality of life for any elderly person is diminished in the slightest way because of neglect, it is a concern to us as citizens in this commonwealth and in this country, the same as for children. Neglect may not lead to battering, but we deal with many families who neglect members who are vulnerable. They never batter them and we have no evidence because "ye neglect, ye will eventually batter," but neglect is enough. Neglect is enough! We don't need to wait until someone is battered. We also know that we need to establish legislation so that we can protect the elderly. We need not wait until we can document that abuse or neglect exists. I do not care to prove who did it. Community outrage would like to prove who did it. I would like to protect the elderly. You cannot do that by having to find out who did it.

Two years ago, I dealt with a case of an infant with 17 stab wounds. It was clear to me that this child who was still alive had been abused. I did not see that there would be any question of that. However, the very fine defense attorney for the parents said, 'oh, isn't this terrible, this is assault and battery, we must go into court on assault and battery' and I said, 'oh no, you don't.' I had no way of proving, did the mother do it? Did the father do it? Did the babysitter do it? Did a kook on the street come in and do it? But I knew this kid was abused and I was going to protect that child. Please do not get into any trap in your excitement and outrage if we're going to get those guys who do this or these women who do this by having this moved into the criminal court. If the victim wants the criminal court, they may use it. But please don't obscure with the glare of 'we are going to get the criminals.' Please keep yourself illuminated with 'we are going to protect elder citizens' and you can only do this, I assure you, if you keep it under a civil code which needs only to prove, not beyond any reasonable doubt, but just to be able to prove with a preponderance of evidence that abuse or neglect exists.

Someone has talked about the fact here that clients resist help. Sure. Sure, they resist help. The families will resist the help, the victims themselves will resist help because of their concerns about possible retaliation, because as has been pointed out of their own guilt, 'they shouldn't have lived so long.' They are saying to themselves over and over, 'if I weren't hanging around, at least they'd have my insurance money. If I weren't hanging around, they could use what little there is left, I am eating up all my savings with my medication or whatever.'

This is impressed on the elderly over and over, not by people who mean to do it necessarily, but it's a fact of life. The gas prices are going up. If you have an elderly person sitting home tonight and you have been in a gas line all day and you had to pay over a buck a gallon for your gas(you are going to go home and make some aside comment about 'boy, I can't even afford to fill the tank anymore.' And that elderly person will think it is their fault you can't fill the tank. You see, it is not necessarily something we want to do. Now, an early definition of the group that has worked on this symposium has talked about willful abuse. I also do not care whether it is willful or not. I must share with you that willful has nothing to do with it. Focus on the client, focus on are they abused or neglected. Don't focus on, did somebody mean to do it? If it is done, it's done. It's not a fault thing. You are working with a situation so take the word willful out because although many of us do harm other people, we certainly are not doing it willfully.

We have talked about the fact that our clients frequently do not think they have a problem. This is why you will need skilled professionals to join with you and collaborate. We must get together, and Howard Segar pointed this out very clearly, so that we are talking with each other about the services. We find that in all families, when we go in, somebody says to us, "Us? We have a problem?" or, "Change our way of life? Why, we've lived this way all of our life. Why should we change our way of life?" And then the professional stops and thinks, yes, that's true, what right do I have? And then all the self-determination courses go through your head and you say, "I guess I don't have a right to even be knocking on this person's door." Let's give people the right to knock on doors, ask questions, let's get the value that we do talk to each other and yes, we do have a right to question the quality of life for the citizens in the community. Yes, we can use volunteers for much of our work. I would only suggest that the volunteers don't only need to be coordinated and typed up as clerical, they need to be educated. Our fantasy of each one of us is that we are going to go rescue some poor, unfortunate human being. I have been in the field for 30 years and I have never rescued anyone. This is not the point of the work we do, you see, but it can certainly be the fantasy of a volunteer who is very eager to save someone. Nobody wants to be saved. Little kids don't want to be saved.

I was reflecting about an 8 year old boy that I worked with many years ago who lived in the Philadelphia dump with his father. His rather beat him over the back with a shovel. He could not go to school because the dump is not in the school district. So he had never been to school. I thought of how stupid I was in those early years of practice because I kept putting him in foster homes farther away from the dump. All it meant was it took him longer to run home. Kids don't want to be saved, adults don't want to be saved. We must not see ourselves as rescuers, we must have exactly what Dr. Mahoney said in his opening statement, a rational plan. We need to illuminate and not glare. We need to reduce our outrage and in doing this, diminish our myopia. We cannot say there's none of that here. It is all around us.

I testified before a Governor's Committee on Children and Youth in another State for 2½ hours one morning about their cases of sexual abuse of children. At the end of that session, 2½ hours of cases, two reporters came up to me, one on either side, and both said the same thing. I had said it was in their State, which was a nasty thing for me to do, but the reporters statement was "it's not in our part of the state, is it?" You are all hoping it's either in the housing projects, or in the country, or in the ghetto, in the combat zone. It's everywhere and the myopia of all citizens needs to be reduced. The outrage needs to be reduced. The very careful planning needs to be increased. That's what I think today represents for each of you. I congratulate you on what you're doing. Thank you.

Mr. Drinan. Thank you very much, Mrs. Bailey. They saved the best for the last. I, too, want to congratulate everybody who structured this and Mr. Bergman and all his colleagues who did the extensive study. I can assure you that you've had an impact upon one Congressman and that we will be intensively interested in every development in this area. Before we break for lunch, I wonder if Mr. Bergman will want to talk or if Mr. Steve Day has an announcement.

[A few short announcements presented from audience.]

[Whereupon, at 12 p.m., the briefing was adjourned.]

APPENDIX 1

LEGAL RESEARCH AND
SERVICES FOR THE ELDERLY,
Boston, Mass., November 16, 1979.

Congressman ROBERT DRINAN,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN DRINAN: Enclosed are the corrected copies of testimony presented by Legal Research and Services for the Elderly's Jim Bergman, Helen O'Malley, Howard Segars and Karen Meyers as well as the original transcript of all the testimony presented at the briefing on elderly abuse before the House Select Committee on Aging held in Boston on June 23, 1979. We have also included, for entry into the record, a copy of Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals, Elder Abuse: A Review of Recent Literature, An Analysis of Protective Service Systems for Handling Abuse Cases and Recommendations for Abuse Reporting and Handling Legislation. These documents were prepared as part of our work on elder abuse under a grant from the Massachusetts Department of Elder Affairs. Forgive our delay in getting all this to you.

We were pleased with the June briefing and we hope that it will pave the way for further hearings and consciousness-raising forums on the issue of elder abuse. So much remains to be done! We are continuing our work in this important area and are grateful for the support of people, like yourself, who are interested in the well-being of elder citizens.

If we can be of any further assistance, do not hesitate to call.

Sincerely,

JAMES A. BERGMAN.

LEGAL RESEARCH AND SERVICES FOR THE ELDERLY—ELDER ABUSE IN MASSACHUSETTS: A SURVEY OF PROFESSIONALS AND PARAPROFESSIONALS

ACKNOWLEDGEMENTS

Project staff wish to acknowledge the assistance given them by the following individuals and organizations. Without this assistance, our survey on elder abuse would not have been possible:

Julia Herskowitz, Director of Planning, Massachusetts Commission for the Blind.
Janice Roundy, Coordinator, Community Health Relations, Massachusetts Hospital Association.
Martin Lawsine, Assistant to the Director, Judy Panore, Training Coordinator, Massachusetts Criminal Justice Training Council.
Carolyn Davis, Executive Director, Massachusetts Association of Community Health Agencies.
Peg Monroe, Executive Director, Massachusetts Council of Homemakers/Home Health Aide Services, Inc.
Myra Gordon, Legal Counsel/Research Monitor, Massachusetts Department of Mental Health.
Christine Spurgeon, Legal Research and Services for the Elderly.

This project was funded through a contract from the Department of Elder Affairs of the Commonwealth of Massachusetts. Without this support this project would not have been possible. Project staff wish to express our sincere appreciation to the Department for both its financial and personal support.

EXECUTIVE SUMMARY

Purpose and Methods

This report presents a preliminary overview of information on Massachusetts elders who reside at home and who have been abused by members of their family, friends, caretakers, or other household members during the past eighteen months. The report is based upon data gathered from a survey of 1044 professionals and paraprofessionals which was conducted during March and April 1979. Five types of information were collected:

—professions seeing elder abuse
—characteristics of abused elders
—characteristics of persons engaging in abuse
—brief description of the incident(s)
—response(s) to the incident.

Thirty-four percent (34%) of the surveys were returned, of which 183 or 55% indicated a citing of elder abuse within the past eighteen months. An additional 19 surveys reported instances of multiple abuse (more than one person being abused) and were not coded for analysis.

In interpreting findings, remember that:

—The survey was designed to yield descriptive data only. From this type of information other, more analytical studies can be designed regarding the extent of abuse and variables associated with abuse.

—The 183 *citings* of elder abuse gathered from the survey do not necessarily represent 183 *cases* of abuse; persons responding to the survey could have been reporting on the same case in some instances.

—Possibly duplicated case counts (as explained above) mean that only the grossest findings should be accepted with any degree of confidence.

—This survey does not represent a random sampling of any population. Therefore *all* findings generated through the survey must be tested through more controlled research techniques. *Survey findings are not generalizable beyond this data set.*

Significant Findings

1. Survey respondents reported 183 citings of elder abuse occurring in Massachusetts over the past eighteen months. (Please note that "citings" do not represent an unduplicated count of abuse cases.)

2. Almost all professions surveyed indicated that they knew of cases of elder abuse, with visiting nurses, hospital social services directors, private social service agencies and home care corporations accounting for the majority of abuse citings.

3. Incidents of abuse tended to be recurring events and not single occurrences: 78% of the respondents indicated the abuse had occurred twice or more.

4. Outside (third-party) observation tended to be the primary means of identifying abuse cases: in at least 70% of the abuse citings, someone other than the victim or his/her family brought the case to the attention of concerned professionals or paraprofessionals.

5. Physical trauma constituted over 41% of the reported injuries and included bruises, welts, cuts, punctures, bone fractures, dislocations and burning. Other types of abuse included verbal harassment, malnutrition, financial mismanagement, unreasonable confinement, over sedation and sexual abuse.

6. Victims of abuse were likely to be very old (75 and over) rather than younger (60–75).

7. Women were more likely to be abused than men, regardless of age.

8. In 75% of the abuse citings, the victim had a mental or physical disability which prevented him or her from meeting daily needs.

9. In 75% of the citings, the victim lived with the abuser and in 84% of the citings, the abusing person was a relative of the victim.

10. Almost three-quarters of the surveys stated that the abuser was experiencing some form of stress such as alcoholism or drug addiction, a long term medical complaint or long term financial difficulties.

11. Often (in 63% of the surveys), the elder victim was a source of stress to the abuser, primarily because the elder required a high level of physical or emotional care from the abuser (such as personal care, preparing meals and administering medication) or was financially dependent on the abuser.

12. A wide variety of intervention strategies were described by respondents, including referral to social services agencies, counselling, arrangements of in-home services and removal of the victim. Temporary or permanent removal of the victim from the abusive situation was frequently cited.

13. 70% of all surveys indicated that some barrier to service provision was experienced by workers. A particular problem was the refusal of the victim to acknowledge the problem or allow corrective action to be taken. Reasons given for this inaction were fear of retaliation or shame. Respondents cited the lack of legal protection for workers who wish to intervene in the abuse situation. Lack of respite care facilities, temporary shelters and protective services for elders were also cited as barriers in dealing with abuse cases.

These findings, while requiring verification, raise some interesting questions regarding the nature of elder abuse:

—Is dependency (whether age or disability related) a primary variable in identifying cases of abuse and how do age and sex contribute to that variable?

—Does the proximity of the elder to the abuser (living arrangement) contribute to the potential for abuse? How does relationship of the abuser to the abused contribute to the abuse situation? Are these two variables related?

—Do younger members of a family in which elder (or other) abuse occurs acquire a tendency to be abusers or abused?

—Is there a relationship between the stability of early family life and the likelihood of abuse?

—What are the primary presenting symptoms in abuse cases? Can these symptoms or conditions (physical or emotional) be described with sufficient confidence to give practitioners some guidelines in identifying potential cases of elder abuse?

There are many theories which may be useful in helping us understand elder abuse. This survey has made a first step toward exploring two variables which may be present in some abusive situations (impairment of the elder, stress upon the abuser). It is essential, however, that we identify as many researchable hypotheses as possible and not just the two which formed the basis for this initial survey. By ignoring or inadequately investigating some theories, we may lose a potentially effective treatment for abuse, since our solutions tend to be determined (and limited) by our explanations for why something occurred. The end product of our research should be, after all, the identification or strengthening of effective means for isolating and treating elder abuse and alleviating the conditions which appear to promote it.

INTRODUCTION AND METHODOLOGY

Introduction

This report presents a preliminary analysis of information on the abuse of elders in Massachusetts within the past eighteen months (October 1977-March 1979 approximate). This information was collected through a survey of medical, legal, police and social work professionals and paraprofessionals during March and April, 1979. The survey yielded five types of data:

—*professions which see elder abuse* (for example: visiting nurses, home care corporation staff, hospital staff);

—*characteristics of the abused person* (for example: age, sex, race, religion, physical and mental functioning, household composition);

—*characteristics of the abuser* (for example: relation to abused, stressful situations affecting the abuser);

—*description of the incident(s)* (for example: types of injuries sustained by the abused elder, narrative description of the incident);

—*response to the incident(s)* (for example: emergency action taken, referrals, barriers to service delivery).

The report text and summary tables present the major findings.

Purpose

Little organized knowledge exists to date on the problem of elder abuse, defined as the physical abuse of elderly persons at the hands of their children, other relatives, friends or caretakers. Child battering has received considerable attention over the past fifteen to twenty years since Kempe, et al., described the "battered child syndrome".[1] Spouse battering has now been identified as another form of familial violence occurring in staggering proportions (estimates of as many as two million cases per year of wife battering have been made by Steinmetz, et al.) [2]

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[1] Newberger, Eli H. "Child Abuse and Neglect: Toward a Firmer Foundation for Practice and Policy": American Journal of Orthospychiatry. 47 (3); July 1977, pp. 374–376.

Current literature on violence within the family focuses almost exclusively upon these two forms of abuse. The bulk of this literature describes studies which attempt to identify the causal antecedents to abuse, trying to answer the question "why does it happen"? A handful of researchers however, such as Suzanne Steinmetz and Marilyn Block, are beginning to relate their findings to another population: elderly residing at home.[3]

While abuse of elderly living in institutions, such as nursing homes or rest homes, is a phenomenon which receives sporadic attention from the media and government agencies, the problem of elderly who are abused in their own or their family's home has gone largely undetected and unrecognized. Little information exists on the extent of the problem, what this form of abuse looks like, who sees it or what can be done about it.

The purpose of this survey is, therefore, to provide *preliminary* data on the nature of elder abuse. Does the phenomenon "elder abuse" exist and if so, what professions see it, what does it look like, what are some characteristics of the abuser and the victim and what action(s) do people take when they recognize or suspect that abuse has occurred?

Data gathered in this type of survey yields *descriptive* information which will, we believe, be useful in designing more analytical studies on the extent of elder abuse in the population at large and the variables associated with the abusive situation. It should be emphasized that data generated from this preliminary survey are a first step in the study of elder abuse and should be viewed as part of the design phase for other, more controlled, and hence, generalizable studies.

A second purpose for conducting this survey is to raise the awareness of professionals and paraprofessionals regarding elder abuse as a potential differential in their diagnosis of elderly clients. The elder who "falls down a lot" could just as easily be a victim of abuse as s/he could be experiencing the frailities of advanced age. Until workers with elders add abuse to their vocabulary, the problem may continue to go undetected.

Methodolgy

Definitions

For the purpose of the survey, *abuse* is defined to mean: "the willful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or willful deprivation by a caretaker of services which are necessary to maintain mental and physical health."

Elder is defined as: "any person sixty (60) years of age or older and residing in a non-institutional setting, including persons living alone, with family or friends or with a caretaker."

The definition of abuse selected for this survey is a broad one. While the definition clearly eliminates self-neglect, willful neglect by a caretaker (relative or non-relative) is included. In its most severe form, willful neglect is difficult to distinguish from physical abuse. For example, a person who is confined to bed and intentionally deprived of proper diet or medication is suffering from what some would call neglect and others abuse. The survey attempts to capture information on this type of case by stipulating that the neglect must be willful, i.e., intended. Because "intentions" are difficult for an observer (in this case the survey respondent) to determine, however, the broadening of the definition increases the likelihood that survey responses will include other, less willful forms of neglect.

By including "debilitating mental anguish" in the definition, the survey includes as an abused elder, persons who are suffering anxiety or fear of another person so great as to impair physical or mental functioning. The fear of being beaten or punished, whether that punishment actually occurs, may be as serious a form of abuse as the actual act of striking the elder. Again, as with neglect, the interpretation of "debilitating" when left to the respondent, may result in some citings which are only remotely related to physical abuse and would more properly fall into some other category of mistreatment or injury, such as "intimidation".

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[2] "Beating Up Hubby"; Human Behavior, 7; November 1978, p. 60.

[3] O'Malley, Helen, "Elder Abuse: A Review of Recent Literature"; Legal Research and Services for the Elderly, Elder Abuse Project; Boston, Massachusetts; May, 1978.

The broadening of the definition to include "willful neglect" and "debilitating mental anguish" may therefore inflate the citings of abuse elicited through the survey. Because this is an exploratory survey, however, a broad definition encompassing many aspect of trauma seems an appropriate first step in identifying various "models" or types of abuse. The analysis of data does not distinguish between these models.

In the discussion of one question, however, (What Does Elder Abuse Look Like?) data are separately analyzed in order to provide figures on the relative number of physical abuse citings (e.g., beatings, kicking) vs. other forms of mistreatment (confinement, verbal harassment, etc.).

Instrument Design and Pre-Test

In February, 1979, project staff conducted a literature search on violence in the family, including in particular readings on child abuse and spouse abuse. Survey forms developed by the University of Maryland Center on Aging for its study on elder abuse were also reviewed.[4] Based upon this literature search, staff developed a survey which consists primarily of multiple-choice questions. Some open-ended questions (for example: describing the abusive incident or action taken) were also included.

The survey includes items requiring primarily factual answers although certain judgmental decisions are requested (eg. was the abused person a source of stress to the abuser?). Because instructions did not stipulate that responses be based upon written agency case records, reconstruction from memory may have been relied upon by an undetermined number of respondents, thus increasing the opportunities for inaccurate reporting of data.

The survey attempts to elicit information along two primary dimensions which are cited in child abuse literature as possible variables relating to abuse:

—impairment of the abused person.
—stressful situations affecting the abuser.

A third type of variable, psychological traits of the abused person and abuser, was judged too difficult to capture in this type of survey. The survey focuses rather on the more observable characteristics of the abuser and abused person, data likely to be available in case records of those professions which were surveyed.

While this type of descriptive survey is not designed to test hypotheses, researchers had two theories in mind as they developed the survey:

1. the person being abused is likely to be very old *or* physically or mentally disabled and is likely to be dependent on the abuser for his/her care (impairment of the abused person).
2. the person committing the abusive act is likely to be experiencing some form(s) of stress other than the abusive situation (such as job loss, medical problem, or alcoholism) to which has been added the care of the elder (stressful situations affecting the abuser).

Questions selected for the survey, therefore, tend to elicit data along these two dimensions. There are many other theories of abuse, (pathological individual behavior, culturally determined behavior, learned role model, intergenerational model) which may apply to certain cases of abuse. These and the above two hypothesis can neither be confirmed nor disproved by the current survey. Survey results should indicate, however, potentially fruitful areas for further investigation, particularly along the two dimensions cited above.

Professions to be surveyed were selected because of their degree of contact with the elderly population and/or their likelihood of seeing abused elders.

A pre-test was conducted at the MGH-Chelsea Health Center, Chelsea, Massachusetts among five staff (nursing, social work and psychological professions) who had previously reported citings of elder abuse. The instrument was also reviewed by state agency research staff familiar with survey technique. Instrument revision resulted from both the pre-test and review.

Data Collection

Stamped, self-addressed surveys were sent to 1044 professionals and paraprofessionals during the month of March, according to the following schedule:

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[4] "Study on Elder Abuse"; Center on Aging, Division of Human and Community Resources; University of Maryland, College Park, Md. 1978.

Profession/agency	Schedule	Number sent	Method
Accredited visiting nurses associations	Statewide mailing	132	Survey sent to all agency directors.
Certified homemaker/home health aide agencies.	do	50	Do.
Hospital social service directors and hospital emergency room nursing supervisors.	do	163	Survey sent to all hospital administrators who are members of Massachusetts Hospital Association with instructions to forward survey to: (1) directors of social services and (2) nursing supervisors.
Home care corporations	do	28	Survey sent to all agency directors.
Department of Public Welfare Regional Protective Services Managers.	do	6	Survey sent to all regional managers.
Legal aide agencies, lawyers and paraprofessionals.	Selected mailing	109	Survey sent to agencies/individuals included in Elderly Legal Coalition mailing list.
Police	do	163	Survey sent to crime prevention officers and graduates of "crime and elderly" training sessions for police personnel.
Private social service agencies (includes councils on aging and senior centers).	do	168	Survey sent to agencies included on United Way listings of Massachusetts social services agencies.
Other (eg. other health agency staff, nutrition programs).	do	62	Survey sent to other agencies/individuals included on Elderly Legal Coalition mailing list and Massachusetts Hospital Associate mailing list.

Mailing lists were compiled with the assistance of state-wide organizations representing these professions. Although duplicate addresses were eliminated whenever possible, approximately 29 agencies received the survey twice.

Persons receiving the survey were asked to complete the form within three weeks, making additional copies of the blank survey for each case of elderly abuse being reported. No surveys were accepted after May 4, 1979.

Completion rate

355 surveys were returned to LRSE; this represents a completion rate of 34%. Of the 355 surveys returned, 19 were eliminated because more than one citing of elder abuse was reported on each form, making data tabulation difficult. 4 additional surveys were eliminated because information was too unclear to be tabulated. Of the remaining surveys, 183 (55%) reported a citing of elder abuse within the past 18 months. When multiple count surveys (those which were eliminated from analysis) are taken into account, the percentage of returned surveys citing abuse rises to 57%. 149 returned surveys (42%) reported seeing no abuse during the past 18 months.

Unit of analysis

Each survey reporting on one abused elder is considered to be one *citing* of abuse. This survey has uncovered 183 such citings, in addition to 19 citings of abuse cases involving more than one elder (for example, a couple being abused by their son).

Citings *do not* represent unduplicated counts of cases of elder abuse. That is, several survey respondents could have reported on the same case of abuse. It is important to remember that 183 citings of abuse do not represent 183 elder persons who have been abused. This survey does not lend itself, therefore, to estimating the incidence of elder abuse in Massachusetts. Additional, more controlled studies will be required before estimates of incidence can be made.

Because single cases of abuse may have been counted several times, data may be skewed; interpreting survey results, especially in those categories in which a relatively small number of responses were coded, is made more tenuous because of this factor. In general, therefore, analysis of survey data concentrates on the grossest findings, i.e. those in which one data element is overwhelmingly selected by most respondents when answering a particular question.

Validity and generalizability

This survey permits the respondent, abuser and victim to remain anonymous. This was done in order to protect the confidentiality of client identity and to encourage a higher response rate on the part of survey recipients. Anonymity does mean, however, that survey results are not verifiable.

This survey does not represent a random sampling of any population. Hence, survey results are not generalizable beyond this particular data set. This is especially important to keep in mind in reviewing the findings.

ANALYSIS OF SURVEY RESULTS

A. Does elder abuse exist?

Initial results indicate that professionals who were surveyed are encountering cases of abuse. 183 of the 332 surveys returned (55%) stated that the respondent knew of at least one case of elder abuse occurring during the past 18 months. The abuse cases described ranged from inability or unwillingness of a caretaker (relative or non-relative) to provide essential services to that of repeated physical battering by a family member. The types of mistreatment uncovered by the survey include financial mismanagement, confinement, physical trauma, malnutrition, threats of physical harm, abandonment, sedation (over-medication) and sexual abuse.

Perhaps one of the most significant findings of this survey is that incidents of abuse tend to be recurring events and not single occurrences. Of the 1183 surveys citing abuse, 70% indicated the abuse occurred more than twice. Another 8% reported that the abuse happened at least twice.

While the data do not permit us to estimate the incidence of elder abuse, demographic trends towards an increasing elderly population and the recurrent nature of abuse make it likely that we will see more rather than less of the problem.

Summary Tables 1 and 2 follow and display data on citings and recurrence of abuse.

SUMMARY TABLE 1.—DOES ELDER ABUSE EXIST?

		Total surveys returned (n=355)			
	Number	Percent of total surveys returned	Percent citing of abuse	Percent eliminated	Percent of analyzed surveys (n=332)
Number surveys citing abuse	202	57			
Number citing single cases (coded)	(183)		52		55
Number citing multiple cases (not coded)	(19)		5	5	
Number surveys citing no abuse	149	42			45
Number surveys eliminated for unclear data (not coded)	4	1		1	
Total number surveys returned	355	100	57	6	
Total number surveys analyzed (coded)	332	94		6	100

SUMMARY TABLE 2.—DOES ELDER ABUSE TEND TO RECUR?

	Number	Percent of citings (n=183)
Abuse has happened:		
Once	14	8
Twice	15	0
More than twice	128	70
No answer	26	14
Total	183	100

B. Who sees elder abuse?

The following chart displays the number and percent of surveys sent to each professional/paraprofessional group (column A), the number and percent of surveys returned by each profession (column B), the number of abuse citings per profession (column C), and the response rate per profession (column D).

These data indicate that within the past eighteen months, elder abuse was cited by all but one professional/paraprofessional groupings that were surveyed. Some professions, such as visiting nurses, hospital social services directors, and private social service agency staff were responsible for large numbers of citings of abuse. 109 of the 187 citings are attributed to these three professional groups. We must bear in mind however that these professions also received a proportionately large number of the surveys which were sent out (47%) and this may account for the high number of citings attributed to them.

CHART A

PROFESSIONS SEEING ABUSE

Profession	A		B		C		D
	Surveys sent		Surveys returned		Abuse citings per profession		Response rate (percent)
	Number	Percent	Number	Percent	Number	Percent	
Visiting nurse	132	13	83	24	46/132	35	63
Hospital social services director	163	16	56	16	33/163	20	34
Homemaker/home health aide staff	50	5	17	5	10/50	20	34
Home care corporation staff	28	3	22	6	20/28	71	79
Emergency room nursing supervisor	163	16	22	6	5/163	3	13
Public welfare protective service	6	1	4	1	0/6	0	67
Private social service agency staff/social worker[1]	195	19	49	14	30/195	15	29
Lawyer/paralegal	109	10	24	7	18/109	17	22
Police officer	163	15	33	10	6/163	4	20
Other	35	3	27	8	18/35	51	44
No answer			7	2	1		
Total	1, 044	101	[2]344	99	187/1, 044	18	32

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[1] Includes mental health center staff.

[2] This total is greater than the number of surveys returned (332) because several surveys indicated dual professions.

For this reason, we cannot rely solely on absolute numbers of citings per profession in order to understand who sees abuse. Columns C and D are useful in helping us examine our data more carefully.

We see for example in Column D that certain professions have a much higher response rate than others. For example, home care corporation staff who received 28 surveys, returned 22. This professional group also reported 20 citings of abuse out of the 28 surveys distributed to them (Column C). This means that 80% of the surveys sent to them were returned and 71% of the surveys sent to them were returned citing abuse. This is a much higher response and citing rate than any other profession, even though the absolute number of citings reported is much less for home care corporations than for some other professions.

Similarly high response and citing rates are found in the professional category labelled "other" which consisted of a small number of health-oriented professionals (such as nurses and medical social workers), probation officers and other persons who primarily provide services to elders. Visiting nurses, hospital social services directors and home/health aide staff also displayed relatively high rates of response to the survey (63%, 34%, and 34% respectively) and as professional groups, had reasonably high abuse citing rates with reference to the number of surveys sent to them.

These data would indicate that as future studies or responses to elder abuse are developed, the professions specifically mentioned above should play a key role both as potential sources of research data and as professions most likely to see and, hence, deal with abuse.

The data displayed on Chart A is also interesting in its negative findings. Surveyed groups which produced the lowest citings of abuse were emergency room nursing supervisors, police and welfare protective service managers at the regional level; yet one might expect each of these professions to know of cases of elder abuse in their role as mediators of family violence. This survey can only raise the obvious question of why these key professions cite so few instances of elder abuse.

While these data provide us with some interesting findings, we remind the reader that in no instance were *all* members of a profession surveyed. In some cases, only agency directors received surveys: in others (police, for example) a self-selected and non-representative segment of the profession was surveyed. Additional research will be required, therefore, in order to more accurately determine the relative involvement of each profession in abuse reporting and treatment and to explain the variables which shape this involvement, such as professional awareness of abuse, degree of contact with elderly clients, completeness of reporting/case record forms, levels of abuse in the profession's case load, and access to home environments.

Summary Table 3, which follows, displays raw data on the number of abuse citings reported by each professional group.

SUMMARY TABLE 3.—WHO SEES ELDER ABUSE?

Profession	Number surveys sent to profession	Number returned surveys (coded)	Abuse citings		No citings	
			Number	Percent of surveys returned by profession	Number	Percent of surveys returned by profession
Visiting nurse	132	83	46	55	37	45
Hospital social service director	163	56	33	59	23	41
Homemaker/home health aide staff	50	17	10	59	7	41
Home care corporation staff	28	22	20	91	2	9
Emergency room nursing supervisor	163	22	5	23	17	77
Public welfare protective services manager	6	4	0	0	4	100
Private social service agency staff/social worker	168	49	30	61	19	39
Lawyer/paralegal	109	24	18	75	6	25
Police officer	163	33	6	18	27	82
Other	62	27	18	67	9	33
NA		7	1	14	6	86
Total	1, 044	[1] 344	187	54	157	46

[1] This number is greater than our n of 332 coded surveys because some surveys indicated dual professions.

C. How were cases of abuse brought to the respondent's attention?

The need for direct contact with the victim of abuse is indicated by the findings which describe how abuse citings were made. Only 24% of the abuse citings were brought to the respondent's attention by the victim. A major portion of the citings were obtained either from personal observation by the respondent (24%) or by a co-worker (19%). Equally remarkable is the small number of referrals made by the legal profession, police and medical doctors as a means of uncovering abuse. As in our previous discussion (Who Sees Abuse), we ask why certain professions whom one might expect to be called in cases of domestic violence and/or trauma, account for such a small percentage of reports of elder abuse. Is it that these professions do not see abuse, do not recognize it when they see it, or tend to deal with the problem in isolation from other professions? A survey or study more specifically designed to elicit data on these professions might clarify this question.

Perhaps our most interesting finding in this area was that in at least 70% of the abuse citings, involvement of a third party (someone other than the victim or his/her family) was required before the case was brought to the attention of concerned professionals or paraprofessionals. This suggests the need for some form of outside (third party) observation as a means of identifying abuse cases.

Data also indicate that 1 in every 5 citings of abuse was reported to the respondent at least twice. Additional analysis of survey data could yield information on the ways in which abuse citings are brought to the attention of each profession. Do home health aides become aware of abuse in different ways than visiting nurses or private social services staff? Time did not permit this analysis for this report.

Summary Table 4 presents data on how respondents became aware of instances of elder abuse.

SUMMARY TABLE 4.—HOW WERE CASES OF ABUSE BROUGHT TO THE RESPONDENT'S ATTENTION?

Sources of abuse citings number		Percent of total sources (n=226)	Percent of citings (n=183)
Personal observation	43	19	24
Coworker	35	15	19
Subject (self report)	43	19	24
Member of subject's family	10	4	5
Subject's friend or neighbor	13	6	7
Private agency	38	17	21
Public agency	8	4	4
Hospital or clinic	18	8	10
Police	4	2	2
Private medical doctor	5	2	3
Lawyer/paralegal	0	0	0
Other	4	2	2
No answer	5	2	3
Total sources	226	100	
Total citings	183		[1]124

[1] Indicates that some respondents checked multiple sources who brought abuse to their attention.

D. What does elder abuse look like?

The most frequently cited injury inflicted on the abused elder was bruises and/or welts (44% of all citings). Debilitating mental anguish followed (40%), with other types of injuries being recorded less frequently. Multiple injuries were frequently cited by respondents. These data are displayed in Summary Table 5 which follows this section.

Chart B below aggregates injury data into six major categories and more clearly distinguishes between the instances in which the elder suffered some physical trauma primarily related to battering and other categories of abuse or neglect, such as malnutrition or freezing.

CHART B

INJURIES SUSTAINED BY THE ABUSED ELDER[1]

Injuries	Number	Percent of all injuries (n=309)
Physical trauma:		
Bruises and welts; wounds, cuts and punctures; bone fractures; abrasions and lacerations; sprains; dislocations; skull fractures; burns, scalding	126	41
Major (bone fractures; sprains, dislocations; skull fractures)	22	7
Minor (bruises, welts; wounds, cuts, punctures; abrasions, lacerations; burns, scalding)	104	34
Debilitating mental anguish	74	24
Malnutrition	30	10
None apparent	25	8
Sexual abuse	6	2
Freezing	4	1

[1] This table does not present data on all categories of injuries; therefore column totals have been omitted.

We see that physical trauma constituted 41% of all reported injuries. 34% of the injuries are minor trauma such as bruises, welts, cuts or punctures, while 7% are major trauma including skull or other fractures and dislocations. The categories labelled "none apparent" (no apparent injury) and "other" tended to be used to describe incidents in which no apparent physical injury could be identified, but in which the respondent felt that "neglect" had taken place. "Neglect" was sometimes of a serious nature (eg. permitting an elder to remain in his/her own feces) but more often than not was left unclarified by the respondent.

In addition to analyzing the injuries sustained by the abuse victim, research staff reviewed narrative descriptions of the abuse situation provided by respondents. In reading these brief narratives, staff attempted to classify abuse into the most frequently occurring types or models. Each abuse citing was classified into 1 of 7 categories. The primary presenting problem was unclear in 33 of the 183 citings of abuse, but in 96 citings, *physical trauma* in which the elder

SUMMARY TABLE 5.—WHAT DOES ELDER ABUSE LOOK LIKE?

Injuries	Number	Percent of all injuries (n=309)	Percent of total citings (n=183)
a. Bruises, welts	81	26	44
b. Debilitating mental anguish	74	24	40
c. Other	32	10	17
d. Malnutrition	30	10	16
e. None apparent	25	8	14
f. Wounds, cuts, punctures	12	4	7
g. Bone fractures	12	4	7
h. Abrasions, lacerations	10	3	5
i. Sprains, dislocations	8	3	4
j. Sexual abuse	6	2	3
k. Freezing	4	1	2
l. Skull fractures	2	1	1
m. Burns, scalding	1	0	1
n. NA	12	4	7
Total	309	100	[1] 168

[1] Indicates respondents checked multiple injuries.

had been battered in some manner was the presenting condition. 20 citings were primarily *verbal harrassment* situations, 16 were citings in which *malnutrition* was the chief complaint, 8 constituted *financial mismanagement* (such as withholding rent and food monies from the elder) and 7 were primarily citings of *unreasonable confinement. Over-sedation* and *sexual abuse* occurred in 1 citing each.

These data clearly indicate that *visible* injury to the elder may be present in a large proportion of abuse cases and may serve as a clue in helping practitioners identify such cases.

E. Characteristics of the abused person

Age

In the survey, elder was defined as anyone 60 years of age or older. The survey divided age categories into: under 65, 65–69, 70–74, 75–79 and 80 and over. Results indicate that the largest single age group represented in the survey were elders over 80 years of age, with 66 citings (36% of all abuse citings). The next largest category, ages 75–79, contained 19% of the citings. The smallest age group represented in the abuse citings was the 65 and under category with 9%. These data are presented in Summary Table 6 which is included at the end of the discussion of age and sex.

One reason for examining the abused person's age is to see if abuse occurs or is cited more frequently in one age group than another. Survey results appear to indicate that this may be true for the "over 80" age group.

The number of abuse citings in any age group can, however, simply be a reflection of the relative size of that age group with reference to the total elder population. That is, we may have uncovered more citings of abuse in the over 80 population because that population represents a proportionately large segment of all elders over 60 years of age.

In order to correct for this, we have compared the ratio of abuse citings in each age group over total abuse citings with national census statistics on the proportion of elders over 60 years of age who fall within each of our 5 age categories. This comparison is depicted in Figure 1.

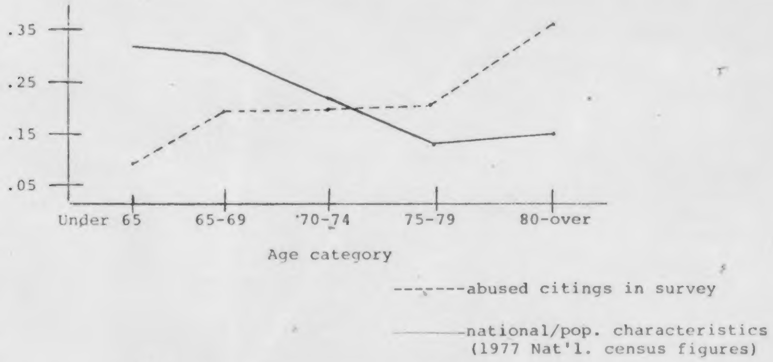

FIGURE 1. Comparison of the proportion of abuse citings within each age group with the proportion of national population in each age group

If abuse occurs in all age groups over 60 with the same frequency, we would expect our findings to mirror the composition of the general population over 60: two relatively parallel lines would emerge in figure 1. This is not the case. Figure 1 shows that for ages below 70, elder abuse was cited less frequently than population figures would suggest. We also find a proportionately greater number of abuse citings in the 75 and over age groups than population figures would suggest.

These data, while by no means definitive, tend to support the conclusion that victims of abuse are more likely to be very old (75 and over) rather than younger (60–75).

Sex

Summary Table 7 shows than in 80% of the 183 citings of abuse the person who had been abused was female. National census figures indicate, however, that women account for only 58% of the population 60 years of age or older. Survey data seem to indicate that women may represent a proportionately larger share of the abused population than their numbers in the general population would suggest.

In order to examine these data more carefully, the ratio of male to female in the national population was compared with the ratio of male to female in our abuse citings *within each* of the five age categories listed in the survey. Figure 2 below depicts these data. Summary Table 8, following this section, displays raw data from which this figure was constructed.

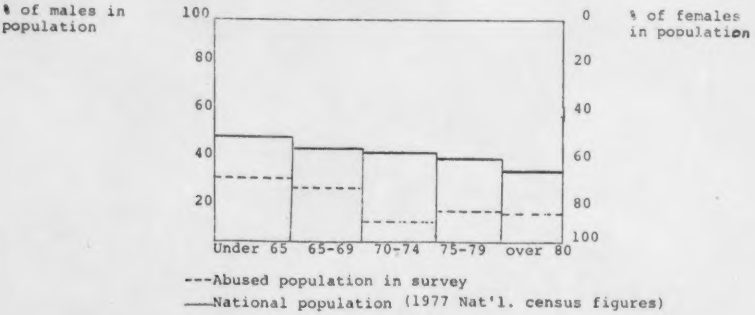

FIGURE 2: Comparison of the ratio of male to female in the national population with the ratio of male to female abuse citings

The figure illustrates that within each age group, the proportion of females cited as abuse victims exceeds the proportion which general population statistics would suggest.

Our survey results thus indicate that women may be more likely to be abused than men across all age categories.

In interpreting both age and sex data, readers are cautioned to remember that—

—this survey was not a random sampling of the abused or elder population nor did it produce an unduplicated count of individual cases. Results may therefore be skewed in some undetermined way.

—it may be that women are more likely to seek assistance or report abusive behavior than men, thus increasing the number of citings in which women appear as the victim of abuse.

—the client population of the professions surveyed may be composed largely of women and/or "very old" elderly, thus skewing our results in these directions.

Additional research will be needed to confirm these findings.

SUMMARY TABLE 6.—AGE DISTRIBUTION OF ABUSED PERSONS COMPARED WITH AGE DISTRIBUTION OF GENERAL POPULATION

Age	Number of citings	Percent of total citings (n=183)	National population [1] times 1,000	Percent of total population
Under 65	17	9	9, 362	28
65 to 69	33	18	8, 446	26
70 to 74	32	17	6, 137	19
75 to 79	34	19	4, 068	12
80 to over	66	36	4, 842	15
NA	1	1		
Total	183	100	32, 855	100

[1] National population 1977 Census Report.

SUMMARY TABLE 7.—SEX OF ABUSED PERSONS COMPARED WITH GENERAL POPULATION

Sex	Number of citings	Percent of total citings (n=183)	National population[1] times 1,000	Percent of total population
Female	146	80	18,906	58
Male	29	16	13,950	42
NA	8	4		
Total	183	100	32,855	100

[1] National population 1977 Census Report.

SUMMARY TABLE 8.—SEX OF ABUSED PERSONS ACROSS AGE DISTRIBUTION

	Sex							
	Males				Females			
	Abuse citings		National population		Abuse citings		National population	
Age	Number of citings	Percent of citings in age category	Number times 1,000	Percent	Number of citings	Percent of citings age category	Number times 1,000	Percent
Under 65	4	29	4,381	47	10	71	4,981	53
65 to 69	8	24	3,739	44	25	76	4,708	56
70 to 74	4	9	2,597	42	29	91	3,540	58
75 to 79	5	16	1,589	39	27	84	2,479	61
80 and over	8	15	1,644	34	55	85	2,198	66
Total	29	17	13,950	42	146	83	18,906	58

Physical/mental disability

In 75% of the abuse citings, the respondent stated that the abused person had a mental or physical disability which prevented him or her from meeting daily needs. It is difficult, however, to draw a conclusion from this data regarding the role which disability may play in the abusive situation. As with age and sex, national or state statistics on disability of the elder population might have been helpful in analyzing these data. Because these statistics are difficult to obtain, a different analysis was attempted. A comparison was made of the number of times disability was indicated within each of the five age categories. One would expect disability to increase with age. Our findings, however, indicate a relatively equal proportion of disability across abuse citings in all five age groups. (See Summary Table 9B.)

This would indicate that our data could be a function of the client population served by the professions which we surveyed. One would expect that these agencies would see a high proportion of disabled rather than self-sufficient elders.

Significant disability does appear to be present, however, in a much higher percentage of the abused survey population than in the elderly population as a whole. We do not know if this is due to sampling artifact (ie, agency case loads having a much higher percentage of disabled patients) or whether disability is independently and significantly correlated with abuse. This issue needs further investigation.

Race/religion

Issues similar to those described above affect data collected on the race and religion of abused persons. We have therefore eliminated this analysis. Raw data are included in Summary Tables 10 and 11, however.

Degree of isolation

Survey data indicate that the majority (75%) of the victims lived with someone else. In only 19% (35 out of 183) of the citings of abuse was the abused person described as living alone. The remaining 6% failed to answer the question. Of those living with someone else, at least 83% (151) lived with a relative and 13% (23) lived with non-relatives. Most surveys (72%) also stated that the abused person had family, friends or relatives outside his or her immediate household. Summary Tables 12, 13 and 14 display these data.

SUMMARY TABLE 9.—DOES THE ABUSED PERSON HAVE A MENTAL OR PHYSICAL DISABILITY WHICH PREVENTS HIM/HER FROM MEETING DAILY NEEDS?

A. DISABILITY

Disability	Number	Percent of total citings (n=183)
Yes	138	75
No	33	18
NA	12	7
Total	183	100

B. DISABILITY ACROSS AGE GROUPS

	Abuse citings		Physical/mental disability	
Age	Number	Percent of total citings (n=183)	Number	Percent of total citings in each age category
Under 65	17	9	14	82
65 to 69	33	18	20	61
70 to 74	32	17	25	78
75 to 79	34	19	23	68
80 and over	66	36	56	85
NA	1	1		
Total	183	100	138	

SUMMARY TABLE 10.—RACE OF ABUSED PERSONS

Race	Number of citings	Percent of total citings (n=183)
Native American	13	7
Black	8	4
Latino/Latina	1	1
Asian	0	0
White	156	85
Other	0	0
NA	5	3
Total	183	100

SUMMARY TABLE 11.—RELIGION OF ABUSED PERSON

Religion	Number of citings	Percent of total citings (n=183)
Catholic	67	37
Protestant	46	25
Jewish	5	3
None	2	1
Other	7	4
NA	56	31
Total	183	100

SUMMARY TABLE 12.—DOES SUBJECT LIVE WITH OTHERS?

Responses	Number	Percent of total citings (n=183)
Yes	137	75
No	35	19
NA	11	6
Total	183	101

SUMMARY TABLE 13.—DOES SUBJECT HAVE FAMILY, FRIENDS OR RELATIVES OUTSIDE THE HOUSEHOLD?

Responses	Number	Percent of tota citings (n=183)
Yes	131	72
No	34	19
NA	18	10
Total	183	101

SUMMARY TABLE 14.—WHO RESIDES AT THE SAME ADDRESS AS SUBJECT?

Residents	Number	Percent of total citings (n=183)
Husband	31	17
Wife	15	8
Son	35	19
Daughter	26	14
Son-in-law	5	3
Daughter-in-law	15	8
Other relative	85	46
Nonrelative	23	13
NA	9	5
Total	244	[1] 133

[1] Indicates multiple persons living with subject.

SUMMARY TABLE 15.—APPROXIMATE INCOME OF HOUSEHOLD

Income	Number	Percent of total citings (n=183)
Less than 5,200	49	27
$5,200 to $9,000	42	23
$10,000 to $14,000	14	8
$15,000 to $19,000	7	4
More than $20,000	3	2
NA	68	37
Total	183	101

Income of household

The surveys indicated that 27% of the households where elder abuse had occurred received incomes of less than $5,200. This question, appeared to be the most difficult question for professionals to answer with a very high no response rate: 68 surveys (37%) failed to respond.

Income findings are supported by the latest census information on income. In the 1977 National Census Report over 60% of those over 65 earned less than $5,000. Census information also showed that the average income of elderly women was significantly lower than elderly men. An interesting hypothesis might be whether the greater financial dependence of women on their families could be a factor which helps to explain the higher proportion of abused women to men which our survey found. The results of the survey do not lend themself to this conclusion but at best indicate that further research may be warranted.

It is possible that many of the professionals who responded to the survey serve primarily low-income clients. If that is the case, our findings on income would merely represent the income classes reached by the survey and not the true population of abused elders. It is important then that the results not be construed to mean that poor elderly are most likely to be abused. Such a conclusion requires more controlled and precise research into this question.

Summary Table 15, which precedes this section, displays data on income of the abused person's household.

F. Information on the abuser

Living arrangement and relationship of abuser to the abused

In 75% (137) of the abuse citings the abuser lived with the person he or she was abusing. In 86% of the citings, the abusing person was a relative of the abused. Sons, husbands and daughters were the largest categories of abusing relatives, accounting for 24%, 20%, and 15% of all abusers. Non-relatives accounted for only 14% of abusing persons. In approximately 1 in every 10 citings of abuse, the abuse was inflicted by more than one person.

While these data indicate that relatives are more likely to be abusers than non-relatives, it may be that living arrangement is a more pertinent variable than relationship in explaining the abusive situation. In that case, results indicating that a high proportion of abusers tend to be relatives may only reflect the fact that elders, especially elders requiring care, tend to live with their families.

Certainly, however, data collected from this survey indicate that elders living with their relatives may constitute a significant portion of the abused population. Tables 16 and 17 display these data and are included at the end of section F.

Stress

The survey also indicated that the abuser was usually experiencing some form of stress when the abuse occurred. 28% of the abuse citings indicated that the abuser was experiencing alcoholism or drug addiction at the time the abusive act occurred. Long-term medical complaints and long-term financial difficulties were also leading categories of stress checked by the respondents. Table 18 displays data on stress being experienced by the abuser.

Because duplicate reporting of individual cases of abuse could have skewed responses to this question, the frequency with which each stress category was checked is less significant than the fact that stress, as we defined it, was present in 74% of the abuse citings. While the relative ranking of stressful conditions remains unclear, stress itself appears to be a potential factor in the abusive situation.

Was the elderly person a source of stress?

Table 19 shows that in 116 (63%) of the surveys which cited abuse the elderly subject (the person being abused) was a source of stress to the abuser. When asked to explain how the subject was a source of stress, 48% of these surveys indicated that the elderly victim required a high level of physical and emotional care from the abuser (such as personal care, preparing meals, administering medication). In addition, another 13% of the surveys indicated that the elderly victim was either financially dependent on the abuser or had severe physically debilitating conditions which acted as a source of stress for the abuser. Summary Table 20 displays these findings.

We also know (see the discussion on Characteristics of the Abused) that 75% of the surveys citing abuse described the victim as having a mental or physical handicap which impaired daily functioning. These two pieces of data would indicate that impairment of the elderly victim as it impacts upon the abuser may be a relevant variable for further analysis.

Other ways were cited in which the elder contributes to the stress of the abuser: nagging, demanding, manipulative behavior on the part of the elder; previous family history of arguments over specific issues (eg. gambling, alcoholism); control of financial assets within the family, and arguments over placement or services for the elder. Each of these types of behavior may constitute variables which are at work in the abusive situation.

Other forms of violence

84% of the respondents either did not know whether other types of violent behavior were present in the abuser's family or stated that no other violence was known to them. This question was ambiguously worded and does not yield itself to interpretation. Summary Table 21 presents raw data on this question.

SUMMARY TABLE 16.—DOES THE ABUSER LIVE WITH THE SUBJECT?

Response	Number	Percent of total citings (n=183)
Yes	137	75
No	35	19
NA	11	6
Total	183	100

SUMMARY TABLE 17.—RELATION OF ABUSER TO SUBJECT

Relation	Number	Percent of total citings (n=183)	Percent of total abuses (n=203)
Husband	36	20	18
Wife	11	6	5
Son	44	24	22
Daughter	28	15	14
Son-in-law	5	3	2
Daughter-in-law	10	5	5
Other relative	40	22	20
Nonrelative	25	14	12
NA	4	2	2
Total	203	[1] 111	100

[1] Indicates that respondents identified multiple abusers in some citings of abuse.

SUMMARY TABLE 18.—WAS THE ABUSER EXPERIENCING ANY OF THE FOLLOWING?

Stress	Number	Percent of the total citings (n = 183)
Alcohol/drug abuse	52	28
Long term medical complaint	33	18
Recent medical complaint	14	8
Recent loss of spouse	11	6
Recent birth of child	3	2
Recent death in immediate family	3	2
Past suicide attempt	3	2
Long term financial problem	30	16
Recent financial problem other than loss of job	8	4
Recent loss of job	6	3
Limited education	24	13
History of mental illness	26	14
Lack of needed services	17	9
Other	31	17
NA	47	26
Total	308	[1] 178

[1] Indicates that respondents checked more than 1 category.

SUMMARY TABLE 19.—WAS THE ELDERLY SUBJECT A SOURCE OF STRESS TO THE ABUSER?

Response	Number	Percent of total citings (n=183)
Yes	116	63
No	42	23
NA	25	14
Total	183	100

SUMMARY TABLE 20.—IF SO, HOW WAS THE SUBJECT A SOURCE OF STRESS?

Types of stress	Number	Percent of total citings of elder related stress (n=116)
Needs care from abuser	56	48
Financially dependent on abuser	2	2
Severe physical/mental disability	13	11
Subtotal	71	61
Other	42	36
NA	3	3
Total	116	100

SUMMARY TABLE 21.—DOES THE RESPONDENT KNOW OF ANY OTHER INCIDENCE OF VIOLENCE OR ABUSE WITHIN THE IMMEDIATE FAMILY OF THE ABUSER?

Responses	Number	Percent of total citings (n=183)
Yes	28	15
Child abuse	(7)	
Spouse abuse	(3)	
Assault/battery	(7)	
Other	(11)	
No	61	33
NA	94	51
Total	183	99

G. Action taken when elder abuse is encountered

Action taken

Most of the 183 surveys citing abuse indicated that more than one type of action had been taken by the respondent in dealing (or attempting to deal) with the abusive situation. In 62% of the citings, some form of direct action was taken. 22% of the surveys stated that emergency action was taken and 48% of the surveys indicated that a referral was made. Data was further analyzed to identify specific action or recommendations made by the respondent, whether those recommendations were accepted by the abused person or his/her family. Summary Tables 22 and 23 which follow Section G display this information.

Under "direct action" the single step most often taken or recommended was described as placement in a nursing home, a hospital, a temporary housing or mental health facility. 36% of all direct action included placing or attempting to place the victim elsewhere. Arranging for in-home services (homemakers, chore, meals on wheels, visiting nurses or home health aides) constituted 22% of all direct action. Coordination of inter-agency treatment plans (16%), counselling or speaking with the abuser (15%) and speaking with the victim (13%) were also cited as forms of direct action.

One half (56%) of all "emergency action" included removal or recommended removal of the victim from the home. Reasons for removal included: medical treatment in a hospital emergency room or hospitalization (39% of all emergency action), nursing home placement (5%), or other placement, such as public housing (12%). Other types of emergency action included calling the police, calling a crisis team or support team and arranging for the household to be monitored.

In surveys which cited "referral" as the type of action taken, referral to social services agencies was the most frequently checked category, with 48% of referrals being made to these agencies. Social services agencies cited include: mental health clinic staff, home care corporations, hospital social services, family services, visiting nurses and public welfare.

Legal services (including legal services agencies, private attorneys, courts and probation departments) represented 20% of all referrals. Police represented 5% of referrals.

Perhaps the most interesting feature of these data is what it tells us about the wide variety of responses which elder abuse elicits in the professionals who see abuse. Referral to social services agencies, counselling, arrangements of in-home services and removal of the victim appear to be the most frequently used intervention strategies. It would be interesting to know whether these responses were appropriate to the specific cases being discussed, a function of what services were available in a given area, or a function of the respondent's professional bias or "style." This is a question which our survey cannot answer.

The wide disparity in skills, approaches and attitudes among respondents is also indicated by the range of responses which we received. Confronting the abuser and telling him/her to stop abusing the victim was one respondent's approach; others called in crisis teams to evaluate the victim and establish interdisciplinary treatment plans for the victim, abuser and family. One wonders, again, whether this wide range of responses to abuse is due to the variables at work in the abuse case itself or to the skills and services available to the responsent who is dealing with the case.

A second interesting finding is the degree to which placement (temporary or permanent removal of the victim from the abusive situation) is cited as a response to abuse. This survey does not permit us to assess the appropriateness of these placements, but in some instances respondents themselves indicate their frustration in finding suitable alternatives to hospitals and nursing homes as places of refuge or respite for the victim.

Barriers to service

One-hundred and twenty-nine (70%) of surveys reporting elderly abuse indicated that some barrier to service provision was experienced by workers. 48 surveys responded with a "no answer" to this question. 4 surveys said no barriers existed.

Of those surveys which reported barriers, the greatest percentage (36%) indicated that the refusal of the victim to acknowledge the problem constituted the barrier. This refusal was variously attributed to "fear of retaliation" from the abuser, feelings of kinship and love for the abuser, or simply as a refusal to accept services.

Fourteen percent of the surveys indicated that a legal problem constituted the barrier to care. Legal problems included:

—lack of legal protection for workers who intervene in the family situation;
—lack of eye witnesses to the abusive act (lack of proof) when abused person refuses to file complaint;
—lack of appropriate person to accept guardianship for the elder (this was cited 4 times);
—requirement of a formal complaint from the abused individual before police can act;
—unwillingness of witnesses to testify;
—lack of formalized statutes protecting elders from manipulation/exploitation.

Thirteen percent of the surveys indicated that lack of cooperation of the abuser and/or family with whom the elder was residing was the principal barrier to services provision. An additional 11% stated that lack of services were the barrier. Needed services which were unavailable included protective services for adults, respite care facilities, temporary shelters which can care for persons requiring assistance in activities of daily living, emergency foster care for elders, and nursing home placements. Lack of coordination among service providers was also cited in this category.

In 9% of the surveys, access to the elder was cited as the barrier to services provision, i.e., the worker was barred from entering the home by the abuser or family. An additional 3% of the surveys stated that agency attitudes were a barrier to service. Examples include a worker deciding that the abuser is "not reachable by counseling", an agency dropping the client because of an obstructive family, a doctor refusing to acknowledge the problem and take some form of action, time demands of the case making a worker reconsider his/her involvement in the case.

Summary Table 24 presents data on barriers to service provision.

SUMMARY TABLE 22.—WHAT ACTION DID THE RESPONDENT TAKE?[1]

Action taken	Number	Percent total surveys (n=183)	Percent within each type of action
Direct action	114	62	
Placement/hospitalization	41		36
Arranged in-home services	25		22
Interagency response	18		16
Spoke with/counseled abuser	17		15
Spoke with/counseled abused	15		13
Spoke with/counseled family	8		7
Emergency action	41	22	
Medical treatment or hospitalization	15		39
Other placement	5		12
Crisis team or support team	3		7
Police	2		5
Nursing home placement	2		5
Referral action	88	48	
Social services	63		48
Legal services	26		20
Other	23		17
Police	20		15
NA	16	9	

---

[1] This table illustrates only the major categories and subcategories of action taken by respondents. Because some data do not appear on the table subcategories do not add up to the number displayed under each major action heading. Because respondents often checked multiple types of action, percentages also do not add to 100 percent. We have therefore eliminated totals on this table.

SUMMARY TABLE 23.—ADDITIONAL ANALYSIS OF REFERRALS

Referral	Number of times cited by respondents
Social services	63
Other/not specified	17
Mental health staff	11
Home care corporation	8
Hospital social services	6
Family services	6
Visiting nurses	5
Welfare	5
Legal	26
Legal services agency	11
Other/not specified	8
Private attorney	5
Court/probation	2
Other	23
Other family or agency	10
Placement (hospital or nursing home)	8
Physician	5

SUMMARY TABLE 24.—BARRIERS TO SERVICE PROVISION

Responses	Number	Percent of total barriers cited (n=129)	Percent of total citings (n=183)
Responses citing barrier	129	100	71
Refusal of services by abused	(46)	36	
Legal	(18)	14	
Family's/abuser's lack of cooperation	(17)	13	
Lack of services	(14)	11	
Access refused	(11)	9	
Agency/staff attitudes	(7)	5	
Other	(16)	12	
No barriers cited	4		2
NA	48		27
Total	181		100

H. Has the problem been resolved?

Forty-five percent of the respondents indicated that the problem of abuse had been resolved and another 4 percent said that resolution was in process. Thirty-six percent said the problem was not resolved. These data are presented in Summary Table 25.

Five of the eighty-two "resolved" citings indicated that the abused elder had died. It is not known whether these deaths resulted from the abuse or were due to failing health and old age.

These data tell us very little about the actual status of the abuse situation. Additional information is needed on the appropriateness of the intervention and the potential for recurrence of abuse in order to describe the status of cases with any degree of confidence.

SUMMARY TABLE 25.—HAS THE PROBLEM BEEN RESOLVED?

Response	Number	Percent of total citings (n=183)
Yes	82	45
No	65	36
NA	29	16
In process	7	4
Total	183	101

SURVEY AND COVER LETTER

LEGAL RESEARCH AND
SERVICES FOR THE ELDERLY,
Boston, Mass., March 6, 1979.

DEAR COLLEAGUE: Legal Research and Services for the Elderly is conducting a study on elder abuse within Massachusetts. This study is sponsored by the Massachusetts Department of Elder Affairs and runs through June 30, 1979.

Your response to this survey is very important to the solution of this growing problem and we urge you to take the time to fill out the attached forms. We are interested in your description of cases of abuse in which the victim is sixty years old or older and residing in a non-institutional setting. This would include persons living alone, with family or friends or with a caretaker. We are interested only in abuse which has occurred within the past eighteen months.

For the purposes of this survey, we are defining abuse to mean: the willful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or willful deprivation by a caretaker of services which are necessary to maintain mental and physical health.

Of course, no names or addresses of the abused person or abuser are requested. Please respond even if you know of no abuse cases. If you know of more than one case of abuse, we ask that you make additional copies of the blank survey forms and complete one set of forms for each case. If you do not have sufficient information to answer a question, please go on to the next question. Answer as many questions as you can, even if this means answering only one or two.

The survey should be returned to Legal Research and Services for the Elderly (LRSE) within three weeks. The survey has been stamped and addressed for your convenience. Please call Helen O'Malley or Howard Segars at LRSE, (617) 426-3401, if you would like additional information about this survey or the elderly abuse project.

Sincerely yours,

JAMES A. BERGMAN.

Enclosure.

1. I am a:

_____ visiting nurse
_____ hospital social services director
_____ homemaker/home health aide staff
_____ home care corporation staff
_____ emergency room nursing supervisor
_____ community mental health center staff
_____ public welfare protective services manager
_____ private social service agency staff/social worker
_____ lawyer/paralegal
_____ police officer
_____ other (specify) _____________
____

2. _____ I know of no cases of elder abuse

3. _____ I do know of at least one case of suspected elder abuse.

Please continue to respond.

---

4. Who brought this case to your attention:

_____ personal observation
_____ co-worker
_____ subject (self-report)
_____ member of subject's family
_____ subject's friend or neighbor
_____ private agency (specify) _______________
_____ public agency (specify) _______________
_____ hospital or clinic
_____ police
_____ private medical doctor
_____ lawyer/paralegal
_____ other (specify)
____
____

5. Check injuries sustained by the subject:

_____ none apparent
_____ bruises, welts
_____ sprains, dislocations
_____ malnutrition
_____ freezing
_____ burns, scalding
_____ abrations, lacerations
_____ wounds, cuts, punctures
_____ bone fractures
_____ skull fractures
_____ debilitating mental anguish
_____ sexual abuse
_____ other (specify) ___________
____

6. Give brief description of abuse:
____
____
____

INFORMATION ON SUBJECT (ABUSED PERSON)

7. Age:

_____ under 65
_____ 65-69
_____ 70-74
_____ 75-79
_____ 80 and over

8. Race:

_____ Native American
_____ Black
_____ Latino/Latina
_____ Asian
_____ White
_____ Other (specify)
____

9. Religion:

_____ Catholic
_____ Protestant
_____ Jewish
_____ None
_____ Other (specify)
____

10. Sex:

_____ Male
_____ Female

11. Does the subject have a physical or mental disability which prevents him or her from meeting daily needs: _____ yes _____ no

12. Does the subject have family, friends or relatives outside the household: _____ yes _____ no

13. Has the abuse happened more than once: ____ once ____ twice ____ more than twice

14. Does the subject live with others: _____ yes _____ no

15. If YES, who resides at the same address:

	Relationship	Age	Sex
1.			
2.			
3.			
4.			
5.			

16. What is the approximate income of the household:

_____ $5,200 or less
_____ $5,300 - 9,000
_____ $10,000 - 14,000
_____ $15,000 - 19,000
_____ $20,000 and over

INFORMATION ON ABUSER

17. Does the abuser live with the subject: _____ yes _____ no

18. Relation of abuser to subject:

_____ husband
_____ wife
_____ son
_____ daughter
_____ son-in-law
_____ daughter-in-law
_____ other relative (specify)____________
_____ non-relative (specify)______________

19. Was the abuser experiencing any of the following:

_____ alcohol and/or drug abuse
_____ long term medical complaint (self or family)
_____ recent medical complaint (self or family)
_____ recent loss of spouse through death or divorce
_____ recent birth of child
_____ recent death in immediate family
_____ past suicide attempt
_____ long term financial problems
_____ recent financial problems other than loss of job
_____ recent loss of job
_____ limited education
_____ history of mental illness
_____ lack of needed services (self or family)
_____ other (specify)______________________________
____
____

20. Was the elderly subject a source of stress to the abuser: ___ yes ___ no

21. If YES, in what way was the subject a source of stress:
____
____
____

22. Do you know of any other incidence of violence or abuse within the immediate family of the abuser: .

_____ child abuse
_____ spouse abuse
_____ documented assault and/or battery on others
_____ other (specify)______________

ACTION TAKEN

23. What action did you take:

_____ direct action (specify) ___________________________________
____

_____ emergency action (specify) _________________________________
____

_____ referral to: police
social services agency (specify) ________________
legal services agency (specify) ________________
other (specify) ______________________________

24. Barriers to provision of service:
____
____
____

25. Has the problem been resolved: _____ yes _____ no

****

Thank you for your help.

If you would like to be interviewed at a later time about the case which you have described (in confidence), please write your name, address and telephone number below. It is not necessary to give this information if you do not want to be interviewed.

I want to be interviewed to talk more about the case I described. I understand that this is voluntary on my part and I may withdraw my consent at any time.

NAME:____

ADDRESS:____

TELEPHONE:___________________________

ELDER ABUSE: A REVIEW OF RECENT LITERATURE

(Prepared by Helen O'Malley)

Violence within the family is a relatively recent subject of social concern. The sanctity of "the home", the autonomy and private nature of the family, is a far older concept than that of family violence as a problem requiring some form of social intervention.

As Steinmetz points out, in the 1960's we "discovered" child abuse; in the '70s we have added spouse abuse and now we see the problem of elder abuse being raised by concerned practitioners. All are forms of familial violence, although certainly child and elder abuse are not limited to a family context. All have in common a victim who more often than not is economically dependent, politically weak and lacking in adequate legal protection.

While sociological and psychological literature documents a high incidence of violence among family members (50 percent of all homicides are committed by family members or lovers), there has been little systematic research into the dynamics of violence among family. Of the three categories of family violence, certainly child abuse has received the most attention in recent years. Traits of the child and the abusing parent are being examined as possible causal factors which would help us explain the existence of this form of abuse. Researchers are also exploring the sources of environmental or societal stress which may be associated with abusive families. While spouse abuse (wife beating or husband beating) has yet to receive the same degree of attention, one can predict that this will become an increasingly important field of study as societal concern makes itself felt.

The recognition of elder abuse within the family context is at an even earlier stage of development. A handful of authors in England and in the United States, most notably Steinmetz and Block, have raised the issue and are conducting primary research which will enable us to better describe elder abuse. Others (Brody, Treas, Tuzil, Seilbach, and Johnson and Bursk) have described the changing relationship of the family vis a vis its oldest generation and the stresses which such relationships may produce.

As yet, however, little is known about elder abuse: we do not know what it looks like, how often it happens, who does it, to whom it happens or what mixture of variables tends to occur in conjunction with the abusive act. Until answers to these questions are found, treatment modes will tend to follow those used in dealing with other forms of domestic violence, and adaptations to existing services and legal systems will likely be made in piecemeal fashion, if at all.

Lessons learned from child and spouse abuse may help us frame our approaches to elder abuse and may give practitioners some guidance in dealing with this problem when they encounter it. Our literature review focuses primarily, therefore, on studies which attempt to identify variables associated with family violence and their implications for practice.

CHILD ABUSE

Child abuse can be *broadly* defined as: any mistreatment, physical or mental, brought about through acts of commission or omission by parents or other care givers or more *narrowly* defined as: intentional, non-accidental use of physical force. In either definition, the line between physical abuse and willful neglect is often difficult to draw, as the list of definitions which accompanies this review shows. Most definitions of abuse appear to include, however, a reference to physical trauma, willfully inflicted. A deliberate act has occurred leading to physical injury of the child (e.g., beating, burning). Definitions of neglect more often focus on the withholding of care. As we move from child abuse to spouse abuse, "neglect" disappears from the vocabulary (perhaps because spouses, as adults, are thought of as being able to care for themselves and hence not subject to neglect at the hands of another), to reappear again in literature on violence to elders, persons who, once again, are often dependent on others for care. Neglect in this context takes on the additional dimension of the elder's ability or inability to care for him/herself. Regardless of the definition which we select, child abuse and neglect "appear" to be on the rise; whether this is actually so, or a function of increased awareness is not known.

Estimates of the incidence of child abuse range from 500,000—2.5 million cases per year, with upper figures probably representing a broadening of the definition of abuse to include neglect. (One of the difficulties in estimating the incidence of child abuse stems from the wide variety of definitions and hence recording procedures, mandated by individual state statutes.)

Historical reviews of state and federal statutes, literature and case records, such as those conducted by Thomas, Pfohl, and Lystad, indicate that child abuse is not unique to our time or culture. Sacrifice of the first-born, Greek and Biblical infanticide, ritual mutilation, concepts of discipline in the English public school system and the use (or misuse) of apprentices, are but a few examples of historically acceptable attitudes toward child care, as cited by Thomas and Pfohl. Before the 19th century, intervention of public authorities in abuse cases was rare. The reformers of the early 1800's, however, recognizing a duty to prevent neglected children from entering a life of crime, created "refuges" (institutions) in which such children could be placed. Public agents were given police powers and children were often separated from abusing or neglectful parents. Abusing parents were sometimes prosecuted and sentenced to prison. Against this model of intervention was set at approximately the same time a preventive model in which service systems were designed to strengthen the home and prevent separation. "The modern social work approach to protection—protection services—tends to avoid the punitive approach, but these differences in concept and philosophy (punitive vs. preventive) have continued to the twentieth century."

The ability to "document repeated injuries to a child over time and to confirm suspicions of abuse" is new to our time, made possible by the developing science of radiology. The "discovery" of the battered child syndrome (spiral fractures of the long bones in infants), described in Kempe's seminal paper (1962), has led in the last fifteen years, to the enactment of child-abuse reporting laws in all fifty states. These laws, requiring doctors and other professionals to report suspected cases of abuse under criminal penalty and immunity from civil liability, also establish central registries at the state level to accumulate data on abuse and track abused children and their parents. In addition, federal statutes have required the development of protective services systems in each state.

. Researchers and practitioners disagree on causes and, hence, strategies for dealing with and preventing child abuse. For example, theories have been developed around the *patho-psychological* characteristics of the parent. Simply stated, these theories attempt to demonstrate that early childhood experiences of emotional abandonment and abuse "create psychological stress, which produces * * * psychopathic states (in the adult). These psychopathic states, in turn cause abusive acts." "Children are used as targets of abuse by parents who are displacing * * * aggression."

Gelles and other theoreticians criticize this type of analysis because it ignores the *sociological and contextual variables* which are associated with the phenomenon of child abuse. In his summary of the literature Gelles cites research which indicated that:

—social class (low economic social status of the abuser);
—sex (the abuser is often female);
—vulnerability of the child (younger children tend to; be abused more than older children);
—societal stresses on the abuser (unemployment, premarital; and conception of the child, marital difficulties)

are relevant variables associated with child abuse.

Lystad points out the popularity of *socialization of aggression* theories, which state that parents who administer severe punishment provide a model for their child who will then severely punish his/her own child. Related theories attempt to explain why these parents socialize their children more aggressively than others, looking to the power structure within the family (the family as a system in conflict) and the power structure within the society as a whole as it impacts upon the family. Gil discusses attitudes in society which condone violence and cities examples of officially sanctioned abuse in institutions, while other authors write about a "culture of violence" specific to certain segments of society.

Sources of ***emotional and physical stress*** on the family provide another fertile area of investigation. These theories maintain that, while certain individuals may have a predisposition to violence because of personality, role confusion as parents, childhood experience or familial or cultural norms condoning violence; situational factors such as general health, opportunity, use of alcohol or drugs, lack of familial and other sources of support and restraint, and acute or chronic stress may be trigger factors which release actual instances of abuse.

Situational factors contributing to stress may be unexpected. Brandon, for example, describes the stresses of motherhood, which are sometimes exacerbated by well-meaning hospital staff. Staff can inadvertently weaken the new mother's coping capacity and sense of self-worth; this may contribute to her later abusive behavior toward the new-born child.

The child, him/herself, may also be a source of stress which triggers violence. Friedrich and Boriskin point out that prematurity (early separation of the mother and child in the hospital), mental retardation, physical handicaps or the parents perception of the child as different (i. e., not adhering to a preconceived role model) may be related to incidents of child abuse.

Data supporting these many theories is confusing and often conflicting. Furthermore, critics point out the inadequacy of this data for predictive purposes and question the conclusions being drawn from what are essentially *ex post facto* analyses. The need, they say, exists for research designs which utilize random sampling techniques and comparative analysis of abusive and non-abusive parents or caretakers along a wide range of variables.

Perhaps the most rational approach to making sense of so many theories of abuse is one in which many variables are taken into account, such as that described by Green, Gaines and Sandgrund Gelles; Friedrich and Boriskin; Davis, Helbert et al., and Sadoff. These theories cite three primary factors relating to child abuse:
—personality traits of the parents (or "abuse proneness");
—characteristics of the child, and
—environmental or situational stress,
and then re-order one-dimensional theories to fit within this broader framework. This approach to explaining child abuse would expect to find parental traits (such as a poor self-concept, impaired impulse control, disturbances in identity formation) interacting with the physical or psychological characteristics of a "problem" child (including both "real" and perceived problem characteristics; i.e., a brain damaged child may present a problem for a parent, but so might a step-child or a child who exhibits traits associated with an unpleasant experience or person in the past). Stress from the environment, such as divorce, birth of another child, illness, unemployment, etc., may add sufficient strain to the parent or family to trigger or sustain an abusive act(s).

This theoretical approach has implications for the intervention strategies which we select to deal with child abuse. Multi-dimensional problems must be addressed by multi-dimensional solutions. Treatment must focus as much on the basic family situation as on the child's needs.

Several authors have pointed out the need to coordinate services at the community level and have called for the provision of intensive family support systems as an alternative to separation of the parent and child. Many cite the need to involve a wide range of professionals and paraprofessionals in the treatment plan and others call for the development of adequate respite care facilities similar to those found in Great Britian.

General agreement seems to exist that the *family* is the critical unit for treatment in child abuse cases and that a wide variety of programs must be made available to high risk families: parenting education, legal counseling, financial assistance, psychiatric treatment, emergency shelter care, homemaker services, day care, and foster homes. Practitioners are questioning the role of "weekly therapy" as an intervention strategy in abuse or neglect cases, realizing that such isolated approaches to care may not begin to address the problems which resulted in abusive behavior. The long term nature of treatment is cited as is the related cost to society of such long-term intervention. Newburger raises the issue of whether we are indeed willing to shoulder the cost and to look seriously at the cultural and societal issues beyond the level of individual cases.

SPOUSE ABUSE

During the past several years, spouse abuse (of both sexes) has received attention, perhaps first from members of the women's movement and then from practitioners, researchers and legislators. Data are scarce, but what data can be found support the conclusion that spouse beating is as widespread a problem as child abuse. "Boston City Hospital has reported that 70% of their emergency room assault victims are women beaten in the home, usually by a husband or lover. In Atlanta, 60% of all police calls received on the night shift are reporting domestic disputes; in Boston, calls average about 45 a day, or 17,277 a year. Almost one third of all female homicide victims in California in one recent year were murdered by their husbands."

Strauss, Steinmetz and Gelles report that 3.8% of the women in over 2,000 American families surveyed "had sustained at least one attack by their husbands in the previous year". This translates into nearly two million beaten wives each year in the United States. The study also found that husbands were as likely to be on the receiving end of violence as wives, with wives being somewhat more frequently and severely violent.

Within the two categories of spouse abuse (wife/husband) certainly research and literature tends to focus on the wife as victim.

As in child abuse, there are myths or stereotypes about wife abuse. Just as we tend to think of child abuse as a problem only occurring in poor families (a stereotype not borne out by data) we assume battered women have asked for their trouble, are of a lower economic and educational status than our own and belong to ethnic minorities. A recent non-representative study however, in Nebraska, "shows that abused women generally are married, that most are white, that they have been victims of both physical and mental abuse, and that poor physical health may be more of a factor than 'masochism' in their inability to break away from a violent situation."

Parker and Schumacher state that little is known about the variables that distinguish battered spouses or their abusers from the general population. As in child abuse, a number of theories have been developed to explain what is now being called the "battered wife syndrome". Parker and Schumacher define battered wife syndrome as "deliberate, severe, and repeated (more than three times) demonstrable injury from the husband", with the minimal injury being severe bruising.

Catharsis or ventilation theories explain this violence as a result of failures in verbal communication between spouses; other theories relate wife abuse to the *social or cultural norms* of society while still others describe this form of abuse as a learned role model. In one of the few controlled studies on wife abuse, Parker and Schumacher found that a "learned role model" may indeed be a relevant factor: their study demonstrated that if the mother in a wife's family of origin was a victim of the battered wife syndrome, there is a statistically significant probability that the wife will be battered by her husband. The study also showed that educational level and alcohol abuse by the husband may be variables in wife abuse.

If wife abuse is vertically transmitted as a learned response from mother to daughter, there are certain direct implications for practitioners. Primary medical doctors, as Parker and Schumacher point out, might be able to break the cycle of violence if medical histories elicited information on patterns of abuse in the family of origin. Certainly, this study would indicate we need more knowledge about the "inter-generational" aspects of both child and spouse abuse.

Society's response to the "discovery" of spouse abuse appears to be following a pattern similar to that of child abuse: first legislative action, then, social services systems development. Legal remedies are being explored which, while not assuring the victim protection from continued physical assault, do require immediate police and court intervention at the request of the victim. Observers in states such as Massachusetts, however, where family abuse prevention laws have been enacted, note that a key issue, only slowly being addressed, is what services should be provided to persons involved in this type of family violence. While separation of the abused from the abuser is more easily achieved under such laws and is a first step in dealing with the immediate violent act, a legal remedy in itself may not be an adequate response to spouse abuse. A wide range of counseling and other services may be required as adjuncts or alternatives to separation and divorce.

One can hypothosize that as more is learned about the variables related to spouse beating, multi-dimensional explanations similar to those being developed in child abuse studies will emerge, requiring multi-dimensional treatment responses.

ELDER ABUSE

Data do not exist on the extent of violence against elders incurred at the hands of family members or other caretakers. While researchers are beginning to explore this problem area current literatue on violence in the family largely ignores the elderly victim.

Steinmetz defines the range of abuse to include benign neglect (tying down an elderly person who needs constant watching, excessive use of sleeping medication or alcohol to make him/her more manageable) as well as more overt forms of abuse (striking parents with fists and objects to make them mind, or to influence their decisions regarding wills, income or signing of other papers). She cites parallels between elder abuse and other forms of family violence, in that the abuser is often providing financial and other support necessary for the victim's survival. Refusal to report for fear of retaliation, lack of alternative shelter, shame and stigma insure that these cases remain undetected. Our own lack of awareness of elder abuse as a possible alternative diagnosis to the bruised elder who "falls down frequently", also keeps this problem hidden.

Steinmetz and Burston have put forth the suggestion that the emotional and financial burden of caring for one's older parents, may be a precipitating factor in this form of family violence. Brody, Tuzil, Johnson and Bursk provide some support for this in their analysis of the aging family.

Brody states that one of the myths of this society is that older people are being abandoned by their children to live in institutions or alone. Figures refute this belief. Bussman and Burchinal point out that as people age, they become more involved with their families than with non-kin or other types of activities; Puner and Butler and Lewis indicate that 80 percent of all older people have living children and 75 percent of them live in the same household or thirty minutes away. Brody states more conservatively that 25 percent of all older people live with an adult child and that 8 percent live in three generation households.

Eighty percent of home care to the aged (age fifty-five and older) is given by family members residing in the same household according to Brody. About 1/3 of these people need constant care of a medical and personal nature, not including food preparation and household maintenance chores.

The stresses of caring for the older person can cause a family to exceed its tolerance level for breakdown. A British study cited by Brody found that 50% of second generation care givers were experiencing symptoms of excessive anxiety and that 30% had insomnia, headache, depression and other symptoms that disrupted the household.

Tuzil describes the feelings of panic and guilt exhibited by adult children or family when they discover they are unable or unwilling to provide care for their parents.

Data indicate that today's middle aged adult is more likely to have a living parent than his/her counterpart in the past and this likelihood is growing every year. This is because our elder population is increasing in size relative to the young: the population sixty years of age or older has grown from 6.4% in 1900 to almost 15% in 1975. Medical advances as well as the historical trend to smaller families, help to explain this phenomenon. In 1900, 4% of the 65+ population were over 85 years of age; in 1975, 8% were over 85. As Treas points out, the typical member of this older population is likely to be a woman, a widow, and *very* old.

What do these figures mean? First, adult children or family may be providing a significant amount of care to an increasingly larger and older elderly population. The chances that each of us may someday be caring for one of our parents are increasing, as is the likelihood that that parent will be quite old and perhaps quite frail. Treas asks what the impact of these demands will be as family resources (emotional as well as financial) become overextended, as women continue to enter the job market (lessening their ability and willingness to care for the at-home parent), and as family size continues to shrink (decreasing the number of adult children who can share responsibility for parent-care).

Are these stresses associated with the phenomenon of elder abuse? At this point in time we do not know. Brody has put forth the tentative suggestion that poor health (within the family) may exacerbate poor family relations, leading to institutionalization of the at-home parent. She also discusses the concept of a "family personality", continuous over time: for example, a family with a long history of conflict might react differently to a stressful situation (e.g., caring for an at-home parent) then might one in which the bonds have been close and warm. In such a conflict prone family, abuse might be the reaction to stress, not institutionalization of the elder.

The University of Maryland Center on Aging is currently conducting research may demonstrate, among other things, that the abused elder tends to be younger and sicker than his/her non-abused counterpart, resides with family and resides in primarily middle-income tracks.

The rationale for these hypotheses is that: (1) the on-set of sickness in a "young elder" might upset the expectations of the adult child for continued maintenance by the parent; in child abuse, the problem of abuse may arise when the abuser's desire for nurturance by the abused is not met; and (2) at-home elders may be more "useful" in a lower-income family than in the middle-income family. This "usefulness" may neutralize the financial stress which families might feel when caring for the elder. Higher income families would not be as likely to feel the financial burden, thus also lowering stress associated with the elder.

As in spouse abuse, we are at the very beginning in framing theories which would help us understand the phenomenon of elder abuse. Before theory building can occur, we must collect information on the extent of the problem and what it looks like. It may be an additional fifteen years before we reach even the durimentary stage in elder abuse theory building that we have now reached in child abuse.

Existing literature on the topic gives us some indication of the direction in which practitioners will look to deal with elder abuse. Many of these articles focus on the need to support families who care for aging relatives in order to reduce the stress associated with that care.

Treas advocates direct subsidies to families who care for their aging relatives, including tax breaks, special allowances and direct reimbursements to family caretakers. Johnson and Bursk agree that practitioners must find ways to alleviate the family's burden in caring for the older parent or relative and call for the development of respite care systems. In addition, they say, support services must be made available to all families, not just low income ones as is currently the case. Brody states that it is vital to sort out the kinds of services which families can provide and those that the community must make available and that we must buttress the family's capacity to help its old. Social workers and community agencies must educate families on what agencies can and cannot do and how to properly use agencies as supports. Education should be geared to explaining to adult children that feelings of frustration and guilt are normal when caring or asked to care for the frail elder.

England has established a system which offers periodic respite help for families coping with aged relations, using volunteers, day centers and geriatric day hospitals. Kenney et al., discuss the "homebuilder" concept in which therapists are on 24 hour call to enter the homes of families in crisis to help prevent the removal of family members to alternative living situations. Paraprofessionals are also used to provide emergency caretaker and homemaker services. Here in Massachusetts, the Departments of Public Welfare and Elder Affairs are funding pilot projects through the Massachusetts General Hospital and other sites to establish foster care programs for elderly and frail patients.

Several authors have dealt with the legal issues which surround elder abuse; as in child and spouse abuse, these issues are complex. All forms of family violence raise issues of privacy, access to the client (authority of practitioners to enter the home), and protection of the victim from further violence or retaliation. Elder abuse, in addition, forces the state to re-examine its guardianship and adult protective services laws. As Regan points out, unless the "all or nothing" aspect of guardianship statutes are amended, the civil liberties of the very persons protective service programs are designed to protect will be threatened. This becomes an issue particularly in cases of abuse and neglect when the elderly person is functionally or mentally incapable of caring for him/herself or has become a victim of a designing person. Regan calls for flexible degrees of guardianship in which only the least necessary restrictions on the civil rights of the subject are permitted.

The principle of the "least restrictive alternative" is one which should apply to all modalities of treatment for abused elders—legal as well as medical and social work practitioners should aim for those treatment options which permit the elder to maintain the greatest practicable degree of self-sufficiency and self-determination while removing or reducing the threat of physical or emotional harm. But as the literature indicates, the least restrictive alternatives to care, such as emergency housing or foster care, are scarce or non-existent in many communities.

The recognition and identification of abuse of the elderly accomplishes little if no service system exists to address the problem or if institutionalization of the elder is the only remedy available to the family and practitioner trying to cope with abuse. Will we, having identified the problem, also organize the systems needed to deal with elder abuse cases? And if this response is forthcoming, can we apply what we have learned from child and spouse abuse to the abuse of the elderly?

A series of questions which seem relevant to elder abuse immediately confront the reviewer of child and spouse abuse literature. Each question would make a worthy topic of study:

—are families in which child or spouse abuse has occurred more likely to also engage in violent acts toward elderly family members?

—does alcoholism or other addiction appear to be a factor in situations of elder abuse?

—what role does stress (eg., loss of job, marital difficulties, illness) play in the abusive situation?

—do elders contribute to stress upon family members engaging in abuse?

—does proximity of the elder (eg., living within the same household) increase likelihood of abuse?

—what role does the dependence of the elder (physical, emotional, financial) play in the abusive situation?

—do abused elders share any physical, emotional or other trait? can they be distinguished in any way from non-abused elders do abusers differ from non-abusive persons in some way other than having committed the abusive act?

—what social or cultural norms in this society condone or encourage violence against elders?

—does violence against elders cut across cultural and/or national boundaries? what are the experiences of other countries in this field?

—historically, how have elders been cared for and treated by family and society? what role do religious teachings play in shaping our views of elders?

—do state statutes provide protection for elders from violent family members? how do these laws work or fail to work for elders?

—is elder abuse more prevalent among a particular age, sex or socioeconomic group?

Our hypothesis for such studies can be derived from our readings on child and spouse abuse and from our knowledge of the aging population. Certainly we have a long way to go toward understanding the dynamics of family violence in general and elder abuse in particular. But readings on child and spouse abuse are clearly a first step in developing that understanding and may also be useful first step in designing our responses to this newly "discovered" problem.

DEFINITIONS OF ABUSE AND NEGLECT

"International, non-accidental use of physical force or intentional non-accidental acts of omission on the part of a parent or other caretaker interacting with a child in his care, aimed at hurting, injuring or destroying the child."

"The 'victim' has suffered physical trauma, sustained in the home, has a repeat history of such injury, is at least 60 years of age, resides in the home of a son or daughter, other relative or with a caretaker. Physical trauma is defined in terms of malnutrition, or injuries such as bruises, welts, sprains, dislocations, abrasions, lacerations and so forth."

"Deliberate acts of commission or omission by parents or other care givers which have seriously harmful effects upon the children."

Battered Wife Syndrome: "woman has received deliberate, severe and repeated (more than three times) demonstrable injury from husband, with minimal injury being severe bruising."

Battered Aged: "elderly parents who reside with, are dependent on and battered by their adult, caretaking children."

Abuse: "the willful infliction of physical pain, injury or mental anguish, unreasonable confinement or willful deprivation by a caretaker of services which are necessary to maintain mental and physical health."

Neglect: "a disabled adult who is either living alone and unable to provide for himself the services which are necessary to maintain his mental and physical health or is not receiving the services from his caretaker."

Caretaker: "an individual who has responsibility for the care of the disabled adult as a result of family relationship or who has assumed the responsibility for the care of the disabled adult voluntarily or by contract."

Disabled Adult: "any person eighteen years of age or over . . . who is physically or mentally incapacitated due to mental retardation, cerebral palsy, epilepsy, organic brain damage caused by advanced age or other physical degeneration in connection therewith, or due to conditions incurred at any age which are the result of accident, organic brain damage, mental or physical illness, or continued consumption or absorption of substances such as alcohol or drugs."

Abuse: "the occurrence of one or more of the following acts between family or household members:

(a) attempting to cause or causing physical harm

(b) placing another in fear of imminent serious harm

(c) causing another to engage involuntarily in sexual relations by force, threat of force or duress"

Family or household member: "household member, spouse, former spouse or their minor children or blood relative."

Abuse: "non-accidental physical injury(s) to child by parent or other caretaker who acts in place of parent if injury causes or creates a substantial risk of death or disfigurement, impairment of physical health or loss or impairment of function of any bodily organ or exposing child to substantial risk of such injury."

Neglect: "severe failure to thrive, malnutrition, lack of medical care and supervision, ingestions or accidents due to inadequate supervision, inadequate food, clothing, shelter, school attendance, dependence upon addictive drug at birth, severe emotional neglect."

Abuse: "inflicted injury, sexual abuse" (two above quotes from Massachusetts General Hospital reporting regulations for child abuse/neglect cases)."

Abuse: "inflicted gaps or deficits between circumstances of living which would facilitate the optimal development of children, to which they should be entitled, and their actual circumstances, irrespective of the sources or agents of the deficit."

"Elderly Patients battered by relative before admission to hospital and in which there has been no doubt that the battering was deliberate."

"Child abuse and neglect means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby . . ."

Child abuse: "primarily physical injuries to a child and unlawful sex acts upon a child. Abuse includes nonaccidental physical injuries to a child by a parent or other caretaker who acts in the place of the parent if the injury causes or creates a substantial risk of death or disfigurement, impairment of physical health, or loss or impairment of function of any bodily organ. Or exposes child to a substantial risk of such nonaccidental physical injuries."

Neglected Child: "any child who does not receive proper care or supervision or discipline from his parent, guardian, custodian or other person acting as a parent, or who has been abandoned, or who is not provided necessary medical care or other remedial care recognized under State law, or who lives in an environment injurious to his welfare, or who has been placed for care or adoption in violation of law."

Abuse: "includes but is not limited to, the wilful infliction of physical pain, injury or mental anguish, or the wilful deprivation by a caretaker of services which are necessary to maintain physical and mental health."

Neglect: "an elderly person who is either living alone and not able to provide for oneself the services which are necessary to maintain physical and mental health or is not receiving the said necessary services from the responsible caretaker."

Abandonment: "the desertion or wilful forsaking of an elderly person by a caretaker or the foregoing of duties or the withdrawal or neglect of duties and obligations owed an elderly person by a caretaker or other person."

Caretaker: "a person who has the responsibility for the care of an elderly person as a result of family relationship or who has assumed the responsibility for the care of the elderly voluntarily, by contract or by order of a court of competent jurisdiction."

Violence: "the intentional use of physical force on another person, or noxious physical stimuli invoked by one person on another. The physical force may be viewed as assaultive, designed to cause pain or injury as an end in itself, sometimes referred to as 'expressive violence', or as the use of pain or injury or physical restraint as a coercive threat or punishment to induce another person or persons to carry out some act, commonly called 'instumental violence. Violence may also be legitimate . . . or illegitimate . . . but behind illegitimate violence are cultural dimensions that involve the acceptance of violence."

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III. SERVICE SYSTEMS ANALYSIS

A. An approach to systems building

Abuse of any person constitutes a serious problem, but abuse of persons sixty and over raises especially difficult questions throughout the community. Police departments, social services agencies, hospital admitting desks and even agencies whose sole focus is the elderly client can be tied in knots by one case of alleged or suspected abuse. Even complaints of abuse supported by eye-witness accounts can be extremely frustrating and time-consuming for the case manager who must deal with other pressing cases.

There are many factors which contribute to the difficulties inherent in managing a case of alleged or actual elder abuse, but two in particular deserve some note. First, more and more frequently, elders are living to a *very* old age and are being cared for in whole or in part by members of their family (see Appendix A: A Review of Recent Literature). Initial results of a statewide survey on elder abuse indicate that the very family members upon whom the elder is dependent for personal, financial, and/or emotional support, are frequently the perpetrators of violence. Thus, when a case worker is faced with an abusive situation (alleged or actual), s/he must be prepared to fill the gaps in services which may result when the family support network is disrupted for a time or permanently. This action requires a degree of services coordination which is not available in many areas.

Second, the coordination of community services, never an easy task in any situation, is made more difficult in instances of alleged or actual abuse because of the complex legal and ethical questions which confront the case worker and because of the possible *emergency* nature of the case. During the training component of this grant, LRSE staff were continually asked by workers with elders how they should proceed in a situation where concern for the safety of the elder client has to be weighed *in a matter of hours* against the right of that client and his/her family to privacy and self-determination. "Who," they ask, "has the authority or responsibility for intervening in such cases, and how can the necessary community resources be mobilized in such a short time?"

In attempting to address these complex issues, LRSE staff have conducted field interviews with persons currently managing elder abuse cases and with national experts; we have conducted literature and statute reviews and, perhaps most importantly, we have examined current approaches to children's protective services in this country.

As detailed in the literature search, family violence, whether wife battering, child battering or battering of elders, is a multi-dimensional problem. Its solution must therefore be multidimensional in scope. This means that those who intervene must be able to respond to the social, legal, financial, emotional and medical needs of the abused person. There may also be housing and nutritional deficits which must be addressed. Meeting such needs requires coordinating a variety of service providers *as well as* developing service alternatives which currently do not exist in most communities. This inter-agency, multi-professional response to elder abuse is crucial to its resolution.

Equally crucial is the need to identify and address the *chronic* conditions which may have contributed to abuse of the elder. As in child abuse, removing the child from the home until parents "cool-off" accomplishes little; counseling, job placement, medical assistance and other services may be required to create a stable home environment in which violence plays no role. Services provision which merely addresses the *fact* of abuse and not the contributing conditions, may serve to exacerbate existing tensions within an already deteriorating family structure. Services to the abused person's *family* are as important as services to the *victim* in any protective services situation.

We should be clear here that we are using the term "family" in a broad context, to include both relatives and other non-related caretakers of an elderly person. Obviously, even in situations where family are not involved, the ability of the service network to address the chronic conditions which permitted abuse to occur is crucial to the well-being of the client and the success of the services system in handling cases.

In the preceding section of this report entitled "Legal Analysis", we have put forth our recommendations for a mandated elder abuse reporting law which, while offering protection to the abused individual, also adheres to the right of that individual to privacy and self-determination. That analysis clearly stresses the need to accompany such legislation with a protective services capacity which can: (1) provide immediate protection to the victim of abuse, (2) coordinate more long-range responses to the chronic conditions which underlay the violent act and (3) provide on-going data on the nature of abuse which will permit us to refine our responses to this serious problem.

In framing our legal analysis, certain principles were set forth which apply equally well to our model for a *protective services system* for abused elders. As we describe that model below, these principles (the client's right to self-determination and least restrictive alternatives to care) are implicit.

Two additional principles play an important role in our proposed model for protective services for elders:

—maintenance and support of the family support network whenever possible

—use of community-based service alternatives as opposed to institutionalization of the victim whenever possible (a derivative of the "least restrictive alternative" principle).

B. A model protective services system

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the state can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model, as set forth below, consists of general systems characteristics which any community should keep in mind when setting up an adult protective services which are largely unavailable in most communities and a delineation services system serving elders, a listing of additional (and important) support services which are largely unavailable in most communities and a delineation of those tasks which could be most efficiently undertaken on a statewide (as opposed to community) level.

1. General systems characteristics.—Within any protective services system there are two essential systems characteristics: first, the necessity of having pre-planned individual case responses or protocols which will enable the system (and its individual workers) to respond quickly *and* properly to the type of case being confronted, and second, the capacity for a coordinated, interdisciplinary response on the part of the service system to both the emergency and chronic conditions exhibited by these cases.

(a) Pre-planned case responses or protocols.—Workers with elders who are confronted with abuse or suspected abuse must know what their options are in each situation. Regardless of the emergency or non-emergency nature of the situation, workers must know the service plan options available to them in their community. To the extent that the case is emergency in nature, the worker's ability to respond or arrange for an immediate response is crucial to the safety of the victim.

Communities who are planning a protective services system for abused elders should set as one of their first tasks the development of protocols for the four basic types of situation with which they will be confronted:

—the client who consents to assessment/service delivery and who appears to be mentally competent

—the client who refuses assessment/service delivery and who appears to be mentally competent

—the client who (regardless of his/her degree of cooperation) appears to lack sufficient mental capacity to make decisions regarding his/her own care

—the client who is in danger of immediate and grievous bodily harm (emergency cases).

There are a number of ways to categorize abuse cases and to develop subsequent protocols. The four categories described above seem the most basic, however, since they have as a point of reference the client's *right* and *ability* to determine the system's response to his/her problems. Also, importantly, the issues confronted by these case typologies (the client's capacity for and right to self-determination) are the very ones which will bring the protective services system to a halt time and time again unless pre-planned responses are available.

For example, workers attending training sessions held by LRSE staff spoke of their feelings of helplessness and paralysis when confronted with suspected victims of abuse who refused assessment and services. Concerns over protecting client' rights in potential guardianship situations and questions about the proper use of legal representation for agency staff *and* clients in such situations was often expressed by workers. These kinds of concerns can be somewhat allayed if agencies have, in writing, a list of steps and time frame which should be followed when workers are confronted with such situations. These protocols serve to protect both the client and worker from lax or overzealous reactions and help assure that the worker remains cognizant of the clients rights to self-determination.

Communities can undertake this development activity now, regardless of the state's administrative or legislative responses to the problem of elder abuse. LRSE staff will also begin to develop model protocols as part of their activities under a Title XX Training Grant for workers with abused elders. A brief discussion of the four basic client groupings outlined above is contained in section C of this part.

(b) Interdisciplinary response.—Abuse is a multi-dimensional problem whose resolution requires input from many service agencies. Services which are available in a given community must be coordinated around individual cases. An efficient means of developing this coordinated response is the formation of a protective services committee composed of representatives of agencies who agree to provide services to abused elders.

The committee's role is two-fold:

—to establish linkages between agencies that will permit services coordination to take place in a timely manner, including the development of protocols as described above, and

—to provide an on-going review mechanism for individual cases.

In some communities this dual function might be played by a single interagency committee; in others, two groups (agency directors; case managers or case workers) may be more logical. These functions might also be performed by a team from *one* agency assigned by the community to handle cases of elder abuse and having its own internal staff capacity to provide a full range of core services.

2. Core Services in a protective services system.—While the services required by individual clients will differ, a protective services network for elders should be able to provide a basic group of core services, many of which are currently available in most communities. These core services can be provided through one umbrella agency or through formal agreements between providers. The formal agreements can be contracts to purchase services, but need not involve a transfer of dollars as has been demonstrated by the Council of Elders Protective Services Project, where service units have been allocated to the Protective Services system by other intra-agency services providers.

(a) Protective services worker.—Because of the many disciplines and services which must be brought together in an abuse case, it is essential that one person be held accountable for managing a given case. This person, the protective services worker, plays a crucial role in linking community resources to the victim *and* his/her family and in assuring the system's response to changes in the victim's environment. Because it is important to treat the underlying causes of abuse, the protective services worker should also be the means for linking the victim's family and, if possible, the abuser, to supportive and counseling services.

Designating specific persons as protective services workers is an important means of assuring the system's accountability to the client; recent literature also shows the importance of a stable and on-going client-worker relationship in successfully dealing with abusive situations.

(*b*) *Case assessment team or workers.*—Once a suspected case of abuse is reported, the system must be able to evaluate the need for services, level of services, and the most appropriate response. In the most complete system, this assessment capacity could be provided through a team composed of a physician with geriatric experience (or a nurse clinician under the direct supervision of such a doctor), a trained human services professional with gerontological and casework experience, a lawyer and a psychiatric case worker.

Not every case of suspected abuse will require a complete evaluation by every member of the team. In some communities, resources might not be available to have such a team permanently on call or in place. In such instances a trained individual could perform an initial assessment, using certain pre-determined protocols for calling in other experts to assure access to a full range of assessment skills.

The assessment team or workers will need to work closely with legal counsel representing the assessment worker and his/her agency. The role of counsel at this point is to *assist the worker* in assessing the legal ramifications of his/her actions vis à vis the client and to provide informed judgment as to the proper steps to be taken by the team or worker in proceeding with the case.

(*c*) *Primary health care services.*—These services may be delivered at-home or on an inpatient or outpatient basis. They include: nursing, care by a physician, hospitalization, mental health services, emergency room services and ambulance services.

(*d*) *Legal services.*—These services include arranging for a legal counsel for the abuse victim who will represent the interests of the victim. In instances where guardianship or other mechanisms which would circumscribe clients' rights, are being contemplated by the protective services system, it is essential that legal counsel for the elder be arranged immediately in order to protect the due process/fair hearing rights of the individual. Legal services may be obtained from local legal services offices and elderly law projects, lawyers' guilds and private attorneys.

(*e*) *Homemaker/home health aide services.*—These services are available through Home Care Corporations and public and private homemaker/home health aide agencies.

(*f*) *Transportation.*—These services may be available through Home Care Corporations, Councils on Aging, religious groups, private charitable organizations and public or private transportation systems. Friends and neighbors may also be helpful in providing this service.

(*g*) *Nutrition.*—These services include meals-on-wheels, congregate meals, shopping and cooking services, and are available through local Title VII nutrition programs, home care corporations, church groups and some private charitable organizations.

(*h*) *Financial assistance.*—In cases of elder abuse, the victim may be dependent upon the abuser for support, an arrangement which can be temporarily or permanently disrupted. It is important therefore for the protective services system to have some cash-on-hand or other means for assisting the client through this immediate crisis and for arranging more long term alternatives. Private or religious philanthropic groups may be helpful contacts in this area.

(*i*) *Police.*—Police should be contacted when the client is in *imminent danger* of bodily harm in order to assure access to the premises and, if necessary, to assist in removing the client from harm. If ambulance services are needed, police can help in arranging this.

Under the new Abuse Prevention Act, police also play an important role in protecting the victim from continuing harm, enforcing restraining or vacate orders and arranging services for the victim.

A role for which police presence is *not* appropriate is in assuring access where imminent danger to the client is not a factor. Indeed, such an overreaction on the part of the protective services worker may set up hostilities in the alleged victim and family which will be difficult to overcome.

(*j*) *Emergency services provision.*—The protective services system must be able to provide immediate services to diminish or prevent the threat of grievous bodily harm or death to a client. This emergency capacity should at a minimum include a 24-hour a day, seven days a week response capacity and the following services:

—emergency housing (at least two nights);

—emergency medical care (in the home or by ambulance to service site);
—emergency funds; and
—legal services (for advice or representation of the client).

Emergency services should not be limited to a crisis intervention posture; clients receiving emergency services should be mainstreamed into the client pool as soon as the emergency has been resolved. Reliance on crisis prevention alone is too often counter-productive because it tends to regard acute episodes *outside* the client's day to day functioning.

(*k*) *Follow-up.*—All cases, regardless of disposition, should be reviewed on a regular basis. An initial review might be conducted by the protective services committee within thirty days of opening a case and each ninety days thereafter. (The long-term nature of abuse cases is discussed in the Literature Review included in this report.)

3. Additional supportive services.—The core services listed above, while not evenly distributed or adequately funded in all or even many geographic areas, do exist throughout the Commonwealth. The need is to organize them into protective services systems and to assure their availability to victims of abuse.

Other important services are currently unavailable, however, and their unavailability seriously weakens our ability to deal with cases of elder abuse. While individual communities may be able to organize these services for their clients, a national or state-wide effort is needed to assure service availability in all areas.

(*a*) *Emergency shelter/housing.*—This need constitutes perhaps the single greatest gap in services to victims of abuse. Workers stated again and again their difficulties in locating shelters for elders and their frustration in having to rely upon hospital and nursing home beds for placement of abuse victims.

In some instances, removal of the victim from the abusive environment is the only way in which she/he can be protected. While hospitals or nursing homes may be suitable placements for certain individuals, alternative, short-term options are needed for many others.

State or federally funded demonstration projects are required in this service area. Until such programs are established, existing community facilities should be coordinated to help provide emergency shelter for elders. These facilities include emergency housing resources for other client groups, convents, dormitories on college campuses, motels, guest houses, and public housing authorities.

(*b*) *Counseling groups for victims of abuse and abusers.*—One of the most difficult problems in dealing with cases of elder abuse is the unwillingness of the victim to talk about it. For various reasons, discussed previously in this report, many battered elders refuse to confront the fact of their victimization. Individualized specialized counseling for abuse victims is often needed *throughout* the investigation, assessment and service delivery phases of the case. Group counseling may also be an effective means for helping the elder cope with his/her victimization. Models for this type of service are provided by existing self-help groups for victims of rape, for example.

We would also urge that thought be given to the formation of similar self-help groups for abusers. Parents Anonymous, an organization of parents who have abused their children, provides us with a successful model in this area.

(*c*) *Foster care for elders.*—Foster care for elders is a new service concept currently being piloted in a small number of areas in Massachusetts. This and other long-range placement options (such as congregate housing) are necessary for victims of abuse who can no longer live alone or who must be removed from their family's care. Alternatives to nursing home placement or hospitalization must be developed for the semi-independent elder.

(*d*) *Day care or recreational/activity centers for elders.*—Respite care for elders (both on a regular, daytime basis and for weekends or longer periods of time) gives families who are caring for their elders some break from these sometimes overwhelming responsibilities. Such a respite may serve as both a safety valve in preventing abuse *and* as a half-way step, once abuse has occurred, which permits families to re-adjust to caring for the elder.

In instances where the abused elder has led an isolated existence, day care and recreational programs can help provide a necessary support structure for the victim.

4. Statewide or uniform service systems characteristics.—The model protective services approach described herein does not assume the passage of a mandated elder abuse reporting law or the designation of a single state agency responsible for handling abuse cases. While we obviously support these concepts, we also believe it is possible for communities to begin framing their own responses to elder abuse within existing administrative constraints. Even with the passage of a mandated reporting law, we would urge a degree of flexibility in the way in which protective services responses are permitted to vary from community to community.

Certain elements of a statewide adult protective services system should be uniform, however, and are discussed below. Communities should not be deterred from start-up activities because such uniformity does not currently exist, however.

(*a*) *Standardized record-keeping.*—The protective services system will be improved by standardized record-keeping which permits audits for service and client characteristics. Records should reflect service goals as well as casework process and should be kept by client number so that confidentiality can be maintained during case reviews. Uniform record-keeping creates both a data gathering capacity for planning purposes *and* a case review capacity which would promote (if not ensure) timely handling of cases, systematic reviews of individual client progress and adequate fair hearing and grievance procedures for clients and their families. An annual report based upon this information should be prepared by the designated state agency.

(*b*) *Uniform eligibility guidelines.*—Adult protective services are Title XX eligible services, which, when included in the state plan, must be provided without regard to income. A serious response to the problem of elder abuse would include the provision of adult protective services through Title XX. The question of whether to include disabled persons over eighteen years of age in any statute which mandates adult protective services, or to confine legislation to the sixty plus population is obviously an important one, since this decision will have an impact on the design of the services delivery system and the total cost of the program.

(*c*) *Uniform system of case finding, reporting, and referral.*—While it is not essential that a *single* agency be designated in each area for receiving reports of elder abuse, or that that agency be identical across all areas of the Commonwealth, it *is* important that this responsibility be clearly pinpointed in each area or community of service. A network of agencies, such as visiting nurse associations or hospitals, could be designated to perform this function and to be responsible for subsequent referral to other community organizations. While Home Care Corporations might be logical choices in some communities, DEA is reminded that other, possibly equally adequate service providers may be available and should not be discounted.

Regardless of which agency(s) is designated in each area or community, its responsibility should be the receipt of abuse reports, assignment of an assessment worker or team to investigate each report and referral of the case to a protective services team or worker (internal or external to the agency) for case planning and services delivery. This agency should receive regular status reports on all referred cases.

(*d*) *Confidentiality.*—LRSE staff found that a great deal of confusion and uncertainty exists around issues of confidentiality as they relate to elder abuse cases. Because of the need for coordinated service responses, it is necessary to share client information across a number of agencies when dealing with cases of elder abuse. In instances where abuse is merely suspected, assessment of the problem may often involve client evaluations by more than one profession. Standardized client release forms and procedures for protecting client specific information, for *each of the four basic client typologies* previously mentioned, would be useful for local communities attempting to establish adult protective services systems. Such uniformity would also go a long way to assuring that the client's right to confidential treatment of identifying information is respected equally in all areas of that Commonwealth.

(*e*) *Training.*—Protective services workers specializing in elder abuse, counsellors, assessment team members, I & R and emergency telephone personnel—indeed, most persons who would participate in a protective services system for abused elders—need training. In other sections of this report we have outlined the complexity of the issues faced when dealing with abuse and the need to sensitize workers to this newly discovered problem. Traditional skills in case management, record keeping, community organization and case work are also essential in the successful handling of these cases. Such on-going training can best be accomplished through state financed and organized efforts particularly through Title XX (SSA) and Title IVA (OAA) Training Programs.

(f) Funding.—Although communities can begin the systems development work outlined above, certain vital services (such as emergency shelters for elders) do not currently exist and require state or federal seed monies. Specialized skills and positions (such as the protective services worker) may not be available in most communities and existing service providers may be unable to guarantee slots or units of service for abuse victims because of existing caseloads or waiting lists. Priority setting at the state level (both programmatic and fiscal) is crucial if a uniform and serious effort is to be made to address the problem of elder abuse. Title XX, Title XIX, Medicare, Title III (OAA), and other sources of services funding should be specifically directed to this problem area.

C. FOUR BASIC CLIENT TYPOLOGIES

The LRSE survey on elder abuse has demonstrated that abuse comes in many forms, from malnutrition to withholding of needed medicines to physical assault. The services which are required to address the immediate and more long-term problems of the abused person and his/her family will vary from case to case.

Regardless of this variation in service need, abuse cases, and adult or elder abuse in particular, present certain common problems to the protective services worker. These problems have to do with the unwillingness and/or inability of some abused persons to consent to services or to even acknowledge the existence (or potential existence) of abuse.

Individual workers and the protective services system as a whole must be prepared for this eventuality, for it will occur and probably quite often. Difficult legal and ethical considerations must be faced when the client is a non-consenting adult; we have also found that the worker's own feelings and frustrations must be confronted and dealt with in such situations.

While we are not prepared at this time to present a definitive set of guidelines for handling such cases, we have begun this task by identifying four basic client typologies which protective services systems for elders will encounter. Specific training and systems building around these basic case models is needed.

1. The consenting client who appears to be mentally competent.—This is perhaps the most straightforward type of case which protective services workers will encounter. Based upon our discussions with existing protective services workers and abuse grant trainees, it may also be the least frequent in occurrence. In this situation, the worker is confronted with a client (the abuse victim) who, regardless of his/her willingness to admit that abuse has occurred, is willing to be assessed for service delivery and to receive necessary services. The client may also be willing (and eager) to deal with the fact of abuse and to participate in the long-term resolution of that problem. This resolution may include legal action as well as social services delivery.

In such cases, the worker's role includes arranging for assessment, developing a services plan (in conjunction with the client and family), working with the client's family to address the problem, and, if necessary, coordinating efforts with the client's attorney or providing assistance to the client in obtaining legal services.

Issues that arise in this type of case may include disagreements over case planning between the client and worker and possibly among the agencies or professions involved in handling the case. The worker's role vis à vis the elder's family may also be problematic, especially if the worker's attitude toward abuse (real or alleged) is one of retribution or anger.

2. Non-consenting client who appears to be mentally competent.—Very different issues are confronted when the client (alleged abuse victim) refuses to see the assessment worker or to accept services delivery. Families, too, may refuse the worker admittance to their home or access to the victim. This presents the worker with an immediate access problem, since currently, workers have no legal authority to enter the home of an alleged victim of abuse.

Should such authority be given through abuse legislation, however, workers will still be faced with potentially hostile households and with elders who fear retribution or feel ashamed of their victimization and therefore refuse services.

The worker's initial approach to the family and elder may help to set the tone of future discussions and may increase the possibility of eventual services delivery. Workers should not be driven by a desire to "punish" the abuser or wring confessions of abuse from either the victim or abuser. The worker's goal, instead, is to attempt to assure the safety of the victim and to address the problems which may have led to the abusive act(s).

In some cases, it may not be necessary to confront the fact that violence or mismanagement has occurred in order to accomplish the primary objective of ending abuse. An overburdened caretaker, in an act of desperation, may strike an elder. In such a situation, relieving the caretaker of some of his/her burden may be all that is necessary to re-establish a harmonious family unit. A wise and caring worker can, over time, bring the victim and caretaker to this realization and arrange for service delivery. The worker's initial objective in such a case is to keep lines of communication open with the client and caretaker so that eventual problem resolution is possible.

In another case, however, of repeated and malicious violence against an elder by a son whose violent nature has already been demonstrated, the worker may very well have to confront the victim with the continuing danger of his/her situation and the need to take legal action against the abuser. The elder may, in that case, very well ask the worker to leave!

Despite the worker's frustrations in this situation, s/he must recognize that the client has a right to refuse services. Again, the worker should strive to keep communication links open with the client and family and may wish to work with other service providers already involved with the family in strengthening the family and client's existing support network. Issues of confidentiality are particularly difficult in this type of case and should be closely examined as the protective services system is being designed. The degree to which the system will "walk away" from a non-consenting client or develop alternatives which do not violate the client's right to privacy and self-determination, constitutes perhaps the most difficult moral issue which the protective services system and worker will face.

3. Client (consenting or non-consenting) who appears to lack sufficient mental capacity to make decisions regarding his/her care.—The primary legal issues involved in this type of case are discussed in the section of this report entitled "Legal Analysis" and include the client's right to self-determination, fair hearing, and legal representation. The worker who confronts a situation where competency is in question must protect the rights of the client by arranging for proper legal representation (if the client has no attorney) and by seeing that the principle of "least restrictive alternative" is adhered to by all concerned parties. This latter task is not a simple one, since existing statutes in most states do not recognize alternative, intermediate forms of guardianship *and* since the most likely guardian, conservator or caretaker of the elder may very well be the abuser.

Designers of a protective services system for elders must develop procedures which ensure that client rights are not violated and that alternate, less restrictive approaches to guardianship are available.

4. Clients in danger of immediate and grievous bodily harm.—Any of the three situations described above may present the worker with an immediate need to protect the victim from further harm. This protection can take several forms:

(*a*) remove the victim from the abusive environment
(*b*) remove the abuser from the presence of the victim
(*c*) inject a third party into the environment who will intervene if abuse threatens.

Currently, the first alternative is most widely in use, since immediate medical care for the client may be required and because the other alternatives are more difficult to institute. Some communities are exploring the use of professional and paraprofessional staff who are sent to live with an abusive family in order to modify abusive behavior. This obviously implies consent on the part of the family and its applicability, therefore, in emergency situations may be severely limited. Removal of the abuser is legally possible under the terms of the Massachusetts Abuse Prevention statute, but because no guarantee of the clients' safety can be assured, this alternative will probably continue to be used less often in emergency situations than removal of the victim.

We have already discussed the need for the protective services system to include emergency living arrangements for elders other than hospitals and nursing homes. Workers should also be urged to explore the use of the alternatives listed above, rather than simply relying on removal of the victim from the scene of violence. Indeed, some cases might arise where options two and three are feasible. The system should have these emergency responses ready and agreed upon by all relevant service providers before case finding is instituted.

D. EVALUATION OF PROJECT SITES

The following is an evaluation of the protective services capacities of the three project sites which were selected to participate in the DEA–LRSE Elderly Abuse Grant *and* which have taken some steps to organize a protective services system for elderly clients. Two sites have not been included in this analysis since no systems building around adult protective services has yet occurred. Since these two sites (Mystic Valley and Minuteman) will obviously be our first contacts for providing technical assistance under the renewed abuse contract, evaluations of each area's capacity for protective services system building will be submitted at that time.

The evaluation presented below does not constitute a judgment of the ability or desire of individual workers or agencies to participate in a protective services system for elders, but rather attempts to outline the systemic approach each site has taken and to assess that approach vis-a-vis the protective services model described in section B of this part. That model includes the following characteristics:

I. General Systems Characteristics:
    A. Pre-planned case responses (protocols)
    B. Interdisciplinary response
II. Core Services in a Protective Services System:
    A. Protective service worker
    B. Case assessment team or worker
    C. Primary health care services
    D. Legal services
    E. Homemaker/Home health aide services
    F. Transportation
    G. Nutrition
    H. Financial assistance
    I. Police—no access, ambulance or imminent danger
    J. Emergency services
    K. Follow-up
III. Additional supportive services:
    A. Emergency shelter/housing
    B. Counseling groups for abused and abuser
    C. Foster care for elders
    D. Day care or recreational activity centers
IV. Statewide or uniform service system characteristics:
    A. Standardized record keeping
    B. Uniform eligibility guidelines
    C. Uniform system of casefinding, reporting and referral
    D. Confidentiality guidelines
    E. Training
    F. Funding

Because highly specific demographics are available through the Title XX Unit of the Massachusetts Department of Public Welfare (cf.: *Regional and Area Profiles;* January, 1979) and through the Executive Office of Human Services (cf.: *Resource Inventory Project* 1978), much of the data contained in this section is drawn from extensive interviews with staff assigned to Home Care Corporations and other social service providers located in the initial five project sites. These five sites, Worcester, Mystic Valley HCC, Minuteman HCC, Merrimack Valley HCC and Boston Area III HCC represent a moderately definitive cross section of the existing approaches to elderly protective services in Massachusetts. Of the five sites, two (Worcester and Merrimack Valley) have on-going protective services delivery mechanisms. Minuteman HCC plans to add a protective services component shortly, while Mystic Valley currently has no staff person or unit targeted for responsibility with regard to protective services and hence, no centralizing focus for a protective services response to elder abuse. Boston Area III has no protective services capacity of its own but participates through an informal referral network with adult protective services available through Department of Public Welfare subcontracts at Family Services of Greater Boston and (to a much lesser degree) the Council of Elders, Inc.

Three different approaches to protective services delivery exist in the selected project sites: Merrimack Valley, Worcester and Boston III. Each is unique to its area. Two are formal; one is informal. None meets the goal of a comprehensive protective services system and none has any statutory guarantee of its existence beyond a given funding cycle.

Merrimack Valley

Description

Merrimack Valley accounts for the second largest population concentration in the Commonwealth. Although twenty-four cities and towns comprise the home care corporation's target communities, the three most populous cities, Lowell, Lawrence and Haverhill, provide the agency bases for the protective services delivery system.

1. Funding

The Merrimack Valley protective services network had available to it for the eight month period between 1 September 1978 and 31 May 1979 a sum of $28,000. $21,000 (or 75% of the eight month total) was generated by a Title III grant under the Older Americans Act. The remaining $7,000 of "in-kind" monies came from the grantee agencies: Family Services of Greater Lawrence, Family Services of Greater Lowell and Children and Family Aid Society of Haverhill. Twelve month funding should maintain the fixed 75%–25% ratio demanded of Title III grantees. Thus, on an annualized basis, the inter-agency network expects $37,333 from Title III with an expected "in-kind" match of $9,333.

Monies contained in the Merrimack Valley proposal were almost entirely applied to salaries for three staff persons. Only $450 has been set aside for emergencies, and according to one agency director in the consortium, that sum has been "carefully watched over and only touched in dire emergencies." One interesting sidelight of that approach is that the network ended their first year with a balance in the emergency funds account.

Ancillary to the grant which funded the Merrimack Valley protective services mechanism was a second Title III grant used to hire, train and supervise "protective services homemakers." This will be discussed in greater detail under the staffing portion of this report.

2. Location

The Merrimack Valley grant's location may well be one of its most innovative points. Begun at the urging of the local Home Care/Area Agency on Aging, Elder Services of the Merrimack Valley, Inc., the grant links three family services associations in Lawrence, Lowell and Haverhill. In addition, case management supervisory staff from the home care corporation have involvement. Not only does this network geographically reach out into the Valley, it capitalizes upon the unique experience of each of the consortium members. This approach to delivery across agency lines insures that the means of coordination of services exists, if the participants choose to use them. Further, accountability is now targeted among the three MSW social workers assigned to each agency. These workers, in turn, are responsible for linking clients with the network of services available in the Valley including referral to and follow-up for most of the services described in our model system.

3. Staffing

The protective services network in Merrimack Valley employs three half-time MSW level social workers. One worker is stationed in each of the family service agencies. In addition to their half-time protective services caseloads, workers also provide casework services to other, less restricted client pools.

One of the more innovative approaches to protective services staffing began through the homemaker services department of Family and Children's Aid Society of Haverhill. Recognizing that protective services clients seem to share common needs characteristics in terms of homemaking, the agency sought Title III funding for a component to recruit, train and supervise a small number of protective services homemakers. In addition to training unique to their client population, these homemakers worked under the direct supervision of a graduate trained psychiatric nurse. Since this nurse splits her time between this core of six to seven homemakers and their clients and a local community mental health center, the protective services network not only has access to a group of well-supervised specialty homemakers, but there is a direct link with the mental health center as well. This kind of service stretching is not unusual in other areas of human services and should be encouraged in the elder services network as well.

4. Case planning and referral

No special mechanism exists for protective services referrals to the three consortium members. Cases do not all come before the consortium sitting as a protective services committee. (Committee meetings are held approximately every two weeks.) Those cases which cannot routinely be handled by a member agency through its own services network appear before the committee acting as a PSRO (Professional Staff Review Organization). Confidentiality is maintained at all times and potential recipients of protective services are "staffed" or "cased" as they might be in a community mental health center or in a health services setting such as a hospital or health maintenance organization. This approach has the same essential value for protective services that it does for any of the service systems where it is already widely used. Not only is group expertise brought to bear on the solution of casework problems, but the group also acts as a self-criticism unit and as a place where common service needs can be discussed and pursued.

Observed during a self-evaluative session in March 1979, committee members admitted that little outreach had been organized around protective services, and that it had largely been limited to the major population centers. Since there is no further elderly protective services casework capacity in any of the areas in question, it is understandable that the principals might be reluctant to advertise something already used to its maximum. If this is true of casework capacity, it is probably safe to assume that much the same obtains for other support services such as homemaking, nutrition, home nursing, etc. Service possibilities also cluster in Lawrence and Lowell rather than in Dracut or Tyngsborough; the unevenness of service availability would no doubt present a problem if outreach were stepped up.

5. Services

The Merrimack Valley protective services network currently has the capacity to provide quick, on-going casework services to consenting clients. Ancillary and support services such as homemaking can be arranged through links to the home care corporation or other members of the service community. Services are intense and coordinated; however, they are dependent upon the referrant requesting the provision of services. Since many of the victims of abuse cited in the 1979 LRSE survey had refused services within the past eighteen months, this restriction of the client pool to those who request services is considerable.

6. Statistical information

In the period 1 March 1978 through 28 February 1979, the Merrimack Valley protective services network provided services to eighty-one clients. Of these eighty-one individuals, it is estimated that between twenty-five per cent and thirty per cent meet the LSRE definition for an abuse victim. Protective services caseloads tend to be low because of the intense and acute character of the intervention strategies required. Workers carried between five and ten cases at any given time. Intervention strategies favored least restrictive alternatives and relied heavily upon home care corporation involvement. Authorizations for service were considerably larger among the protective caseload than among other caseloads.

The Merrimack Valley approach to protective services seems to utilize most (if not all) the service opportunities available within the twenty-four communities which make up the region and to embrace the principles set forth in the LRSE model system. Further, as demonstrated by the protective services homemaker component, the network has the ability to assess need and solicit or develop innovative resources. This is quite obviously an interdisciplinary approach to adult protective services.

Despite these positive factors and despite a well-trained staff willing to collaborate, funding limits the effort to a demonstration project. There is little incentive to advertise the service outside the participating agencies because there is no capacity to grow. Important support services such as emergency shelter are largely unavailable in the area and client access to core services is unevenly distributed between rural/urban areas of the Valley. Further, incentive for resolving such important issues as standardized record keeping, emergency access to services, development of close legal-social services ties and the necessity for conducting outreach, is small when the long-term nature of the project is in doubt.

This system needs to be encouraged to extend itself to include police, legal services and medical providers in a more direct way and to systematize its interdisciplinary case review mechanisms to include protocols for emergency intervention and for dealing with a wider range of clients. (e.g., the non-consenting and/or potentially incompetent client).

Worcester

Description

With the exception of Boston, Worcester is one of the most densely populated regions in the state. Elder Home Care Services of Worcester Area, Inc., the Worcester home care corporation, serves not only the urban area, but fourteen surrounding communities as well, including some rural parts of central Massachusetts. The presence of a teaching hospital and several outstanding universities and research facilities adds considerably to the service and skills base available to area residents.

Elder Home Care decided to develop a protective services capacity after completing a needs assessment of its own caseload. A review of community resources indicated an unmet need for emergency protective services. Although Worcester also has three other protective services grantees, these are all United Way affiliates drawing their funds through Title XX's purchase of service unit of the Department of Public Welfare. None of the three Title XX grantees has the capacity to make in-home assessments, nor are they formally linked to a major service provider like Elder Home Care. Planning staff from United Way of Worcester and from Elder Home Care meet on an informal basis to minimize duplication of service.

1. Funding

Elder Home Care has access to an $18,000 grant from Title III of the Older Americans Act. "That just about pays the salary of the worker and the fringe," was the executive director's comment on the amount of money available to him. In addition to the salary figure, protective services includes an additional $1,000 for client emergencies drawn from another budget. There was no figure available for the cost of worker supervision and back-up.

2. Location

The protective services worker maintains her office at Elder Home Care. Much, if not most of her work, however, takes place on site in clients' houses. In addition to this worker, Elder Home Care also sponsors and hosts a protective services committee which includes workers from other social services agencies, a probate court clerk, a uniformed law officer and representatives from the Visiting Nurse Association and from Central Massachusetts Legal Services. Similar to the system in use in the Merrimack Valley, this committee not only provides a form of PSRO, but it also attends to service deficiencies and devises means to bridge or fill gaps in resources. This committee is, for example, beginning to address the possibility of establishing a relationship with the local community mental health center. LRSE provided some basic information about mandated mental health services for geriatric populations which may prove useful in a proposed collaboration.

3. Staffing

The protective services worker is an MSW social worker. She is supervised and her services are backed up by another MSW social worker. The protective services worker herself provides not only direct services to protective clients, but acts as a resource to case management staff as well.

4. Case planning and referral

Since the protective system is located within the home care corporation, the referral mechanism is usually a direct and internal one. Referrals also are initiated outside the home care corporation and are treated no differently than those which are "in house". The protective services committee is a useful referral sources as well as a means of expediting highly specific needs. The link to probate court, for example, eases at least a few of the problems which arise in terms of guardianships and conservatorships. Similarly the police, often the first people contacted in an elder emergency, have access to a useful service resource.

5. Services

The Elder Home Care protective services component can provide a nearly comprehensive package of protective services. This includes not only emergency, in-home assessment, but crisis counseling by a trained professional as well. Because of its location in a home care corporation, the protective services unit can draw upon homemaking, health aide or chore services in a speedy and expeditious manner. Emergency funds assure that nutritional and housing emergencies can be met on a short term basis. Emergency respite care in a nursing home has been investigated and may ultimately join the services available for protective clients. As mentioned above, probate court problems arising from surrogate authority needs can be partially assisted through a link with the clerk of court's office. Support services such as transportation are available to protective clients as they are available to all clients of the home care corporation.

6. Statistical information

In the past year, Elder Home Care's protective services component has provided services to ninety clients. Of these, sixty-five were female and twenty-five were male. Although the greatest number of clients clustered in the age range seventy-five to eighty-five, four protective services clients were over ninety. There were no figures available for number of possible abuse cases though the worker indicated that perhaps ten to fifteen per cent of her caseload were potential abuse victims. One worker noted that for him the issue was not the difference between abuse and neglect but rather how many clients were high risk. No figures are available about the probable costs of providing comprehensive services to these high risk clients. There was a general agreement among all involved in the program, though, that these high risk clients are in chronic stress situations and enter the protective category during times of acute episodes.

Elder Home Care presents one of the more streamlined approaches to protective services. The use of a community based, interdisciplinary protective services committee adds considerably to the product which the home care corporation is able to delivery Staffing is professional and costs have been kept relatively low. Even though not located in a social work agency, the protective component has professional social work supervision and back-up services.

The protective services operation might be enhanced if it could establish some kind of inter-agency agreement about specific mental health evaluations with or through the geriatric team of the community mental health center serving that catchment area. Ultimately, this kind of inter-agency cooperation might make it possible to begin tracking protective clients and their specific service needs more carefully. Since the protective caseload, even if treated as a series of acute episodes in otherwise chronically troubled lives, will only grow, some thought should be given to growth. Establishing a more careful inventory of client service needs may be one of the best assists to planning for future staffing. As in the Merrimack Valley, specialized support services are in general unavailable to the Worcester Protective Services system and state seed monies are probably necessary to spur the development of important emergency shelters for elders.

Boston Area III

Description

Senior Home Care Services, Boston III, Inc. includes nine inner city communities: Charlestown, Beacon Hill, Mattapan, East Boston, West End, South Cove, South Boston, Dorchester and North End. Although Boston III Home Care serves some of the city's most diverse and crisis-prone neighborhoods, it has no protective services component located within that agency itself. Major protective services grants have been located at Family Services Association of Greater Boston ($250,000) and at the Council of Elders ($435,000). Both these sums represent grants from the Department of Public Welfare's Purchase of Service Unit (Title XX) and neither has any formal link to the Department of Elder Affairs nor to any of the home care corporations in the targeted communities. In addition to these funds (which are restricted by community), there are various other "protective" resources through agencies as diverse as the East Boston Social Service Center and the South Cove Medical Center.

There are few (if any) service *deficiencies* in Boston III in the usual sense of that concept. *Coordination* of existing services constitutes a far greater problem in Boston than does any specific lack of services. This section will attempt to examine some of what is available. Remarkable as it may seem, no single agency has a full listing of resources available in Area III. Information is exchanged orally and informally. Since few workers have an adequate grasp of what is available to them, it is not hard to imagine the sense of frustration elders must feel.

Because funding and location of protective services *capacity* in Boston III is dispersed throughout the area, we have not attempted to describe those resources here.

1. Staffing

Staffing of adult protective services units varies widely. The Family Services Association of Greater Boston uses a combination of graduate trained social workers and undergraduate level "social service technicians". All supervision is provided by MSW's. The Council of Elders, on the other hand, has graduate trained staff only at the supervisory level. (Note: as may be seen in the services section which follows, these decisions about staffing have influence in other service related areas).

In addition to these two major grants for protective services, there are a variety of other more specific protective services available through the Visiting Nurse Association, Greater Boston Elderly Legal Services, Boston University Home Medical and a host of semi-independent neighbohhood health centers. It becomes clear as one investigates the staffing patterns of the various agencies operating in Area III just how diverse the response capacities area. The communities in question do not lack for highly trained personnel. The coordination of those personnel may well leave something to be desired, however.

2. Case planning and referral

Referrals originate and terminate in almost every combination and permutation of agencies and individuals. For intra-agency referrals there is little (if any) predictable follow-up. For example, the local legal services office for older persons refers clients in potentially abuse/exploitative circumstances to a protective services unit *unless* the client is willing to pursue a legal remedy. Most are not ready initially and the referral to a social services provider is appropriate; however, there is no mechanism—other than the older person him/herself—which insures that this interface will be accomplished. There is, of course, no way of knowing how many clients treated in this way actually complete the referral. Most probably do. Some, however, do not.

Inter-agency referrals probably constitute the single most vulnerable point in an agency-client relationship in Boston III.

3. Services

Service for Older Persons (SOP), the Family Services Association's adult protective grant for elders, treats its clients to a form of threshold casework. That is, once the client has reached the point that he or she can be transferred to another, non-protective unit or service provider, that transfer will be effected. Cases "turn around" in six months or less. This approach relies on the wide range of support services available in the Greater Boston area and probably results from the inter-agency work which has long been a hallmark of Family Services Associations. The philosophy is traditional, casework oriented and is enhanced by the use of computer driven analyses of clients and their caseplans. There is a small sum of emergency money available (approximately $2,000) and the occasional possibility of homemaker services through the FSA's homemaker project. Other services, such as medical, nutritional, legal services, are provided through referrals to outside agencies.

The Council of Elders Evaluation Services Program (ESP), the smaller service provider in terms of geographic areas served by Area III, takes a much broader approach to protective services. While the grant is clearly titled "adult protective services", its operation as a unit more frequently resembles a general social services component. Clients tend to remain within the system longer than those in the SOP caseload and it is not uncommon to keep cases open as a safeguard against a likely acute episode. There is no money set aside for specific protective emergencies, though the agency does participate in the Boston Elder Emergency Fund (BEEF), ESP cannot depend upon the Council's homemaking unit for services unless they have been authorized by the home care corporation. Like SOP, the Council's protective services unit depends upon services on referrals for needs in areas other than those covered by the agency itself. The Council does sponsor a day care program for older persons; however, clients must be Medicaid eligible and must be accepted by the Department of Public Welfare's adult day care program. Even this service requires intra-agency as well as inter-agency coordination.

4. Statistical information

There is no uniform system of record keeping in Area III's protective grantees. While aggregate totals are available, it is not possible to determine (in all cases) which were cases of abuse, or even whether the referral originated in Area III. Service for Older Persons lists a very low 1 percent category for abuse cases and prefers to call these "high risk" clients. They do not know, however, how many of those clients at risk fall into the Area III catchment. ESP serves only a small area of Home Care III and does not keep records by home care or origin, but rather, by geographic boundaries which are not necessarily co-terminus with those set by DEA. (This is not surprising since the ESP grant was originally set to follow Welfare Service Office lines.) The lack of even rudimentary data about abuse cases in Area III points out the need for some agreement across agency lines about case reporting and case recording.

Evaluation

While vastly more sums of money are available in the Boston III area (and presumably more skills and problems too!) there is virtually no coordination of services of the sort which characterizes either Merrimack Valley's approach or that of the Worcester protective services committee. Virtually all individuals interiewed agreed that the lack of a "system" constituted an on-going job frustration. Small, but important portions of the service network are being coordinated, however. The SOP supervisor at Family Services Association of Greater Boston meets on a more or less regular basis with service providers in her area, for example; however, she represents (as in Merrimack Valley) a private sub-contractor with no formal link into the Department of Elder Affairs. The Department of Public Welfare does not require any indication of coordination of service delivery as a criterion of its adult protection grants, so there is no formal impetus to do so. While such compulsion could come from the DPW's Purchase of Services contract monitors, that too seems not to happen.

While urban areas are notoriously difficult places in which to coordinate services, successes such as St. Paul/Minneapolis (Hennepin County) argue for attempting the coordination. If coordination does ultimately prove impossible (for whatever combination of reasons), then a free-standing protective services unit may be the only solution for abused elders in the Greater Boston environs. Depending upon the variables impeding coordination, such an approach might be cheaper in the long run. Certainly the Department of Elder Affairs and the Department of Public Welfare should consider the possibilities offered through issuing joint RFP's in the area of protective services.

Protective services system models are available outside Boston. The question remaining is whether these models can be replicated in so diverse an area. Certainly, as a first step, in Boston III, what appears to be needed is a clearly agreed upon mandate for one agency to take the lead in organizing a systems response to abuse in order that one or more of these models can be instituted in whole or in part.

RECOMMENDATIONS FOR ABUSE REPORTING AND HANDLING LEGISLATION

A. Legal recommendations

These recommendations are designed to provide a framework for an abuse reporting law and adult protective services law. They have been drafted by staff members of Legal Research and Services for the Elderly. While accepting the basic principle that society has an obligation and duty to provide protection and care for particular persons who are victims of abuse, neglect, exploitation or abandonment, the recommendations reflect our concern with the rights of the individual to self-determination and due process of law.

Substantive elements recommended to be included in a State protective services and abuse reporting law:

1. The law should apply to persons sixty and older who are abused, neglected, exploited or abandoned and to persons eighteen and older who lack the physical or mental capacity to care for their basic needs and/or protect themselves.

2. Abuse includes, but is not limited to, the wilful infliction of physical pain, injury or mental anguish, or the wilful deprivation by a caretaker of services which are necessary to maintain physical or mental health.

Neglect refers to an elderly or incapacitated person who is either living alone and not able to provide for him/herself the services which are necessary to maintain physical and mental health or is not receiving the said necessary services from the responsible caretaker.

Exploitation refers to the act or process of taking advantage of an elderly or incapacitated person by another person or caretaker whether for monetary, personal or other benefit, profit or gain.

Abandonment refers to the desertion or wilful forsaking of an elderly or incapacitated person by a caretaker or the foregoing of duties or the withdrawal or neglect of duties and obligations owed an elderly or incapacitated person by a caretaker or other person.

All other terms used should be clearly defined in the statute.

3. One state agency shall be responsible for developing an adult protective services program for all citizens. This designated agency or department shall provide services to persons covered by this statute.

4. A report should be required to be made by certain categories of persons including physicians, nurses, social workers, coroners, medical examiners, dentists, hospital staff, nursing home staff, home health agency staff, home care corporation (staff and home makers), clergy, adult foster care facility, police officers, pharmacists, etc.

Anyone of the above categories who has reasonable cause to believe or suspect that an elderly or incapacitated person has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such treatment shall make a report to the appropriate agency within twenty-four hours.

5. Anyone else who has "reasonable cause to believe or suspect" may report this information to the appropriate agency.

6. The identity of the reporting person should be confidential and be disclosed only with the consent of that person or by judicial process. A person acting in good faith who makes a report should be immune from civil and criminal liability.

7. A person required to report but who fails to do so should be liable for a fine of $500 to $1,000.

8. One state agency should be responsible for receiving and investigating all reports. Each report received should be registered by the agency with all available information from the reporter.

The agency chosen to receive and investigate reports should have a system and personnel to: receive reports 7 days a week, 24 hours a day; keep records; have knowledge of services available; have access to services; have a state-wide mandate; and have the ability and staff (trained) to respond quickly.

A centralized intake system should be geared into a regional response system if possible.

The investigating agency should also either provide services or co-ordinate service provision by subcontracting and referral. This should be determined according to existing state service systems.

9. The initial investigation should be conducted by persons trained in human services.

10. Upon receiving a report made in accord with the law, the agency should commence an investigation. This investigation should include a home visit and consultation with service agencies, and persons with knowledge of the case, (including the reporter for further information if possible and necessary). The initial investigation for verification and assessment should be completed within 72 hours. The investigator should have access to a multidisciplinary geriatric team for consultation.

(*a*) If the report is not verified, the case is closed.

(*b*) If the report is verified, an assessment of the individual's functional capacity, the situation and the resources available to the person should be made by a multidisciplinary team with expertise in the particular area of disability.

11. In conducting the investigation, the agency may seek the assistance of law enforcement officials and the courts. If access is denied to the investigator, either by the elderly or incapacitated person or a caretaker, the agency may petition for a court order to enjoin intervention with access to investigate. Such an order shall be issued upon specific facts shown that (1) there is reasonable cause to suspect that the person in question is or has been abused, neglected, exploited or abandoned; and (2) access has been denied to the representatives of the agency required to investigate such reports.

12. Regulations should be promulgated which assure continuity of case management for investigation, assessment, case plan development and service provision.

13. Voluntary services shall be provided upon consent of the elderly or incapacitated individual.

The service plan developed shall provide for the least restrictive alternative, client self-determination, and continuity of care.

A fair hearing procedure should be developed and implemented so that any service plan can be appealed on denial of application for specific services or for failure to provide the least restrictive alternative.

14. The department/agency should establish by regulation a sliding fee scale to be used in determining fees for services provided on a voluntary basis.

The department should maximize all available federal reimbursements for such services. There should be no charge to the individual in question for the cost of the investigation, assessment, etc. These costs are to be borne by the state.

15. If an adult refuses services or withdraws consent, the agency must terminate intervention proceedings. This is consistent with the right of the adult to refuse treatment. The case is closed unless the department seeks to provide services pursuant to involuntary provision procedures.

16. Standards of non-emergency involuntary intervention and services provision must include the following:

(a) assessment of need and eligibility; adult refuses services; lacks capacity to consent; no one else can/willing to consent (See #22).

(b) clear and convincing evidence.

(c) least restrictive alternative; non-institutional placement where possible.

(d) A geriatric/clinical assessment by social worker, physician, mental health practitioner, lawyer to assure appropriate case plan and placement should be required prior to any court order.

(e) Placement shall not be in a mental institution, nor will any proceeding be a determination of incompetency.

17. Any involuntary service provision or placement shall only be authorized pursuant to a court order after a hearing on the merits.

The adult in question shall be assured the right to counsel; if s/he is indigent, the court shall appoint counsel. The adult shall also have the right to be present and to cross-examine the parties involved. If counsel is waived, the court shall appoint a guardian ad litem to act in the interests of the adult in question.

18. Adequate notice should be assured. At least 14 days prior to the hearing the court should order served upon the person and any interested party a copy of the petition and notice including an explanation of the proceedings, the date,

time and location; the proposed service plan; and the rights of the adult in question at said hearing to counsel, to be present, etc.

19. The court order for any protective placement must be specific as to such placement, including reasons for finding it necessary and that it is the least restrictive alternative. This should be stated in the court record.

20. The initial care plan submitted to the court should specify details of services, medical treatment and relocation. The court order issues should be specific as to services, treatment, placement approved.

Any modification can only be made pursuant to court order.

21. The court should limit the order to 6 months or less; upon court review, it can be extended for another period of time (up to 6 months).

22. The determination of "lacks the capacity to consent" should be made according to the following:

> [T]he adult bases decisions on delusions or hallucinations, is unable to make or implement decisions, or is unable to comprehend a decision's effect. The decision itself for refusing services cannot be the sole evidence for finding the person lacks capacity to consent.

23. Involuntary services should be borne by the state unless a court, after a determination of financial ability, orders the client to pay or the client agrees to pay.

24. Standards of emergency involuntary intervention and service provision must include the following:

"Emergency" means that an elderly or incapacitated person is living in conditions which present a substantial risk of death or immediate and serious physical harm to him/herself or others; and a finding based on clear and convincing evidence that—

—the adult in question is incapacitated and in need of services,
—an emergency exists,
—the individual lacks the capacity to consent,
—no one else can/is willing to consent,
—the proposed order is substantially supported by the findings.

25. In issuing an emergency order, the court shall adhere to the following limitations:

(a) The court should specifically order those services necessary to remove the conditions creating the emergency.

(b) Hospitalization or change of residence shall not be included unless specifically ordered by the court upon a finding that such action is necessary.

(c) Emergency intervention should be limited to a period of 72 hours, renewable for 72 hours upon a showing to court of necessity to remove emergency conditions.

(d) Court should appoint a temporary guardian with responsibility for the person's welfare and authority to give consent for emergency services (as ordered by the court) for the duration of the order.

(e) Court should provide that the elderly person is assured all rights except those limitations provided for in the order.

(f) Access to the premises will be ordered by the court to carry out the order in cases where voluntary access has been denied.

26. Notice shall be provided (including relevant and factual information of the basis of the petition) to the person, his/her spouse, children, next of kin or guardian at least 24 hours prior to the hearing.

This notice may be waived upon a showing that (1) immediate and reasonable forseeable physical harm will result from the delay and (2) reasonable attempts have been made to give notice to the above parties.

27. Emergency placement—If it appears probable from the personal observation of a police officer that an elderly person will suffer immediate and irreparable physical injury or death if medical care is not provided, and that person is incapable of giving consent, and that it is not possible to follow the hearing procedures, that officer should be able to transport the person to an appropriate medical facility for medical treatment.

Notice of this action shall be given to persons listed in No. 26 within 4 hours. A petition for emergency intervention should be required to be filed within 24 hours of this action and a hearing should be held with all due process guarantees within 48 hours of the transfer.

28. In all cases, the drafting and adoption of adult protective service provisions, should be linked with the developing of extensive service systems which emphasize alternatives to institutional care.

B. SERVICE SYSTEMS RECOMMENDATIONS: A MODEL PROTECTIVE SERVICES SYSTEM

The model set forth herein does not describe a single client pathway for providing protective services to elders. Communities differ, as do states, in their sophistication, financial means and pre-existing service delivery patterns. We simply do not have the expertise at this point in time to say that one pathway makes more sense than another. We do, however, believe, based upon our experience and upon our analysis of existing protective services approaches, that certain guidelines must be adhered to in order to establish an effective response to the problem of elder abuse. Our model serves as an outline, providing, we believe, a flexible framework which communities and the state can follow in setting up adult protective services systems. The model also provides a basis for assessing the effectiveness of existing networks of care.

The model, as set forth below, consists of general systems characteristics which any community should keep in mind when setting up an adult protective services system, a listing of core services which are essential to any protective services system serving elders, a listing of additional (and important) support services which are largely unavailable in most communities and a delineation of those tasks which could be most efficiently undertaken on a statewide (as opposed to community) level.

1. General systems characteristics

Within any protective services system there are two essential systems characteristics: first, the necessity of having pre-planned individual case responses or protocols which will enable the system (and its individual workers) to respond quickly *and* properly to the type of case being confronted, and second, the capacity for a coordinated, interdisciplinary response on the part of the service system to both the emergency and chronic conditions exhibited by these cases.

(*a*) *Pre-planned case responses or protocols*

Workers with elders who are confronted with abuse or suspected abuse must know what their options are in each situation. Regardless of the emergency or non-emergency nature of the situation, workers must know the service plan options available to them in their community. To the extent that the case is emergency in nature, the worker's ability to respond or arrange for an immediate response is crucial to the safety of the victim.

Communities who are planning a protective services system for abused elders should set as one of their first tasks the development of protocols for the four basic types of situation with which they will be confronted:

—the client who consents to assessment/service delivery and who appears to be mentally competent

—the client who refuses assessment/service delivery and who appears to be mentally competent

—the client who (regardless of his/her degree of cooperation) appears to lack sufficient mental capacity to make decisions regarding his/her own care

—the client who is in danger of immediate and grievous bodily harm (emergency cases).

There are a number of ways to categorize abuse cases and to develop subsequent protocols. The four categories described above seem the most basic, however, since they have as a point of reference the client's *right* and *ability* to determine the system's response to his/her problems. Also, importantly, the issues confronted by these case typologies (the client's capacity for and right to self-determination) are the very ones which will bring the protective services system to a halt time and time again unless pre-planned responses are available.

For example, workers attending training sessions held by LRSE staff spoke of their feelings of helplessness and paralysis when confronted with suspected victims of abuse who refused assessment and services. Concerns over protecting clients' rights in potential guardianship situations and questions about the proper use of legal representation for agency staff *and* clients in such situations was often expressed by workers. These kinds of concerns can be somewhat allayed if agencies have, in writing, a list of steps and time frame which should be followed when workers are confronted with such situations. These protocols serve to protect both the client and worker from lax or overzealous reactions and help assure that the worker remains cognizant of the client's rights to self-determination.

Communities can undertake this development activity now, regardless of the state's administrative or legislative responses to the problem of elder abuse. LRSE staff will also begin to develop model protocols as part of their activities under Title XX Training Grant for workers with abused elders. A brief discussion of the four basic client groupings outlined above is contained in section C of this part.

(*b*) *Interdisciplinary response*

Abuse is a multi-dimensional problem whose resolution requires input from many service agencies. Services which are available in a given community must be coordinated around individual cases. An efficient means of developing this coordinated response is the formation of a protective services committee composed of representatives of agencies who agree to provide services to abused elders.

The committee's role is two-fold:

—to establish linkages between agencies that will permit services coordination to take place in a timely manner, including the development of protocols as described above.

—to provide an on-going review mechanism for individual cases.

In some communities this dual function might be played by a single interagency committee; in others, two groups (agency directors; case managers or caseworkers) may be more logical. These functions might also be performed by a team from *one* agency assigned by the community to handle cases of elder abuse and having its own internal staff capacity to provide a full range of core services.

2. *Core services in a protective services system*

While the services required by individual clients will differ, a protective services network for elders should be able to provide a basic group of core services, many of which are currently available in most communities. These core services can be provided through one umbrella agency or through formal agreements between providers. The formal agreements can be contracts to purchase services, but need not involve a transfer of dollars as has been demonstrated by the Council of Elders Protective Services Project, where service units have been allocated to the Protective Services system by other intra-agency service providers.

(*a*) *Protective services worker*

Because of the many disciplines and services which must be brought together in an abuse case, it is essential that one person be held accountable for managing a given case. This person, the protective services worker, plays a crucial role in linking community resources to the victim *and* his/her family and in assuring the system's response to changes in the victim's environment. Because it is important to treat the underlying causes of abuse, the protective services worker should also be the means for linking the victim's family and, if possible, the abuser, to supportive and counseling services.

Designating specific persons as protective services workers is an important means of assuring the system's accountability to the client; recent literature also shows the importance of a stable and on-going client-worker relationship in successfully dealing with abusive situations.

(*b*) *Case assessment team or workers*

Once a suspected case of abuse is reported, the system must be able to evaluate the need for services, level of services, and the most appropriate response. In the most complete system, this assessment capacity could be provided through a team composed of a physician with geriatric experience (or a nurse clinician under the direct supervision of such a doctor), a trained human services professional with gerontological and casework experience, a lawyer and a psychiatric caseworker.

Not every case of suspected abuse will require a complete evaluation by every member of the team. In some communities, resources might not be available to have such a team permanently on call or in place. In such instances a trained individual could perform an initial assessment, using certain pre-determined protocols for calling in other experts to assure access to a full range of assessment skills.

The assessment team or workers will need to work closely with legal counsel representing the assessment worker and his/her agency. The role of counsel at this point is to *assist the worker* in assessing the legal ramifications of his/her actions vis à vis the client and to provide informed judgment as to the proper steps to be taken by the team or worker in proceeding with the case.

(*c*) *Primary health care services*

These services may be delivered at-home or on an inpatient or outpatient basis.

They include: nursing, care by a physician, hospitalization, mental health services, emergency room services and ambulance services.

(*d*) *Legal services*

These services include arranging for a legal counsel for the abuse victim who will represent the interests of the victim. In instances where guardianship or other mechanisms which would circumscribe clients' rights, are being contemplated by the protective services system, it is essential that legal counsel for the elder be arranged immediately in order to protect the due process/fair hearing rights of the individual. Legal services may be obtained from local legal services offices and elderly law projects, lawyers' guilds and private attorneys.

(*e*) *Homemaker/home health aide services*

These services are available through Home Care Corporations and public and private homemaker/home health aide agencies.

(*f*) *Transportation*

These services may be available through Home Care Corporations, Councils on Aging, religious groups, private charitable organizations and public or private transportation systems. Friends and neighbors may also be helpful in providing this service.

(*g*) *Nutrition*

These services include meals-on-wheels, congregate meals, shopping and cooking services, and are available through local Title VII nutrition programs, home care corporations, church groups and some private charitable organizations.

(*h*) *Financial assistance*

In cases of elder abuse, the victim may be dependent upon the abuser for support, an arrangement which can be temporarily or permanently disrupted. It is important therefore for the protective services system to have some cash-on-hand or other means for assisting the client through this immediate crisis and for arranging more long term alternatives. Private or religious philanthropic groups may be helpful contacts in this area.

(*i*) *Police*

Police should be contacted when the client is in *imminent danger* of bodily harm in order to assure access to the premises and, if necessary, to assist in removing the client from harm. If ambulance services are needed, police can help in arranging this.

Under the new Abuse Prevention Act, police also play an important role in protecting the victim from continuing harm, enforcing restraining or vacate orders and arranging services for the victim.

A role for which police presence is *not* appropriate is in assuring access where imminent danger to the client is *not* a factor. Indeed, such an overreaction on the part of the protective services worker may set up hostilities in the alleged victim and family which will be difficult to overcome.

(*j*) *Emergency services provision*

The protective services system must be able to provide immediate services to diminish or prevent the threat of grievous bodily harm or death to a client. This emergency capacity should at a minimum include a 24-hour a day, seven days a week response capacity and the following services:

—emergency housing (at least two nights);
—emergency medical care (in the home or by ambulance to service site);
—emergency funds;
—legal services (for advice or representation of the client).

Emergency services should not be limited to a crisis intervention posture; clients receiving emergency services should be mainstreamed into the client pool as soon as the emergency has been resolved. Reliance on crisis prevention alone is too often counter-productive because it tends to regard acute episodes *outside* the client's day to day functioning.

(*k*) *Follow-up*

All cases, regardless of disposition, should be reviewed on a regular basis. An initial review might be conducted by the protective services committee within thirty days of opening a case and each ninety days thereafter. (The long-term nature of abuse cases is discussed in the Literature Review included in this report.)

3. *Additional supportive services*

The core services listed above, while not evenly distributed or adequately funded in all or even many geographic areas, do exist throughout the Commonwealth. The need is to organize them into protective services systems and to assure their availability to victims of abuse.

Other important services are currently unavailable, however, and their unavailability seriously weakens our ability to deal with cases of elder abuse. While individual communities may be able to organize these services for their clients, a national or state-wide effort is needed to assure service availability in all areas.

(*a*) *Emergency shelter/housing*

This need constitutes perhaps the single greatest gap in services to victims of abuse. Workers stated again and again their difficulties in locating shelters for elders and their frustration in having to rely upon hospital and nursing home beds for placement of abuse victims.

In some instances, removal of the victim from the abusive environment is the only way in which s/he can be protected. While hospitals or nursing homes may be suitable placements for certain individuals, alternative, short-term options are needed for many others.

State or federally funded demonstration projects are required in this service area. Until such programs are established, existing community facilities should be coordinated to help provide emergency shelter for elders. These facilities include emergency housing resources for other client groups, convents, dormitories on college campuses, motels, guest houses, and public housing authorities.

(*b*) *Counseling groups for victims of abuse and abusers*

One of the most difficult problems in dealing with cases of elder abuse is the unwillingness of the victim to talk about it. For various reasons, discussed previously in this report, many battered elders refuse to confront the fact of their victimization. Individualized specialized counseling for abuse victims is often needed *throughout* the investigation, assessment and service delivery phases of the case. Group counselling may also be an effective means for helping the elder cope with his/her victimization. Models for this type of service are provided by existing self-help groups for victims of rape, for example.

We would also urge that thought be given to the formation of similar self-help groups for abusers. Parents Anonymous, an organization of parents who have abused their children, provides us with a successful model in this area.

(*c*) *Foster care for elders*

Foster care for elders is a new service concept currently being piloted in a small number of areas in Massachusetts. This and other long-range placement options (such as congregate housing) are necessary for victims of abuse who can no longer live alone or who must be removed from their family's care. Alternatives to nursing home placement or hospitalization must be developed for the semi-independent elder.

(*d*) *Day care or recreational/activity centers for elders*

Respite care for elders (both on a regular, daytime basis and for weekends or longer periods of time) gives families who are caring for their elders some break from these sometimes overwhelming responsibilities. Such a respite may serve as both a safety valve in preventing abuse *and* as a half-way step, once abuse has occurred, which permits families to re-adjust to caring for the elder.

In instances where the abused elder has led an isolated existence, day care and recreational programs can help provide a necessary support structure for the victim.

4. *Statewide or uniform service system's characteristics*

The model protective services approach described herein does not assume the passage of a mandated elder abuse reporting law or the designation of a single state agency responsible for handling abuse cases. While we obviously support these concepts, we also believe it is possible for communities to begin framing their own responses to elder abuse within existing administrative constraints. Even with the passage of a mandated reporting law, we would urge a degree of flexibility in the way in which protective services responses are permitted to vary from community to community.

Certain elements of a statewide adult protective services system should be uniform, however, and are discussed below. Communities should not be deterred from start-up activities because such uniformity does not currently exist, however.

(a) *Standardized record keeping*

The protective services system will be improved by standardized record-keeping which permits audits for service and client characteristics. Records should reflect service goals as well as casework process and should be kept by client number so that confidentiality can be maintained during case reviews. Uniform record-keeping creates both a data gathering capacity for planning purposes *and* a case review capacity which would promote (if not ensure) timely handling of cases, systematic reviews of individual client progress and adequate fair hearing and grievance procedures for clients and their families. An annual report based upon this information should be prepared by the designated state agency.

(b) *Uniform eligibility guidelines*

Adult protective services are Title XX eligible services, which, when included in the state plan, must be provided without regard to income. A serious response to the problem of elder abuse would include the provision of adult protective services through Title XX. The question of whether to include disabled persons over eighteen years of age in any statute which mandates adult protective services, or to confine legislation to the sixty plus population is obviously an important one, since this decision will have an impact on the design of the services delivery system and the total cost of the program.

(c) *Uniform system of case finding, reporting, and referral*

While it is not essential that a *single* agency be designated in each area for receiving reports of elder abuse, or that that agency be identical across all areas of the Commonwealth, it *is* important that this responsibility be clearly pinpointed in each area or community of service. A network of agencies, such as visiting nurse associations or hospitals, could be designated to perform this function and to be responsible for subsequent referral to other community organizations. While Home Care Corporations might be logical choices in some communities, DEA is reminded that other, possibly equally adequate service providers may be available and should not be discounted.

Regardless of which agency(s) is designated in each area of community, its responsibility should be the receipt of abuse reports, assignment of an assessment worker or team to investigate each report and referral of the case to a protective services team or worker (internal or external to the agency) for case planning and services delivery. This agency should receive regular status reports on all referred cases.

(d) *Confidentiality*

LRSE staff found that a great deal of confusion and uncertainty exists around issues of confidentiality as they relate to elder abuse cases. Because of the need for coordinated service responses, it is necessary to share client information across a number of agencies when dealing with cases of elder abuse. In instances where abuse is merely suspected, assessment of the problem may often involve client evaluation by more than one profession. Standardized client release forms and procedures for protecting client specific information, for *each of the four basic client typologies* previously mentioned, would be useful for local communities attempting to establish adult protective services systems. Such uniformity would also go a long way to assuring that the client's right to confidential treatment of identifying information is respected equally in all areas of the Commonwealth.

(e) *Training*

Protective services workers specializing in elder abuse, counsellors, assessment team members, I & R and emergency telephone personnel—indeed, most persons who would participate in a protective services system for abused elders—need training. In other sections of this report we have outlined the complexity of the issues faced when dealing with abuse and the need to sensitize workers to this newly discovered problem. Traditional skills in case management, record keeping, community organization and case work are also essential in the successful handling of these cases. Such on-going training can best be accomplished through state financed and organized efforts particularly through Title XX (SSA) and Title IVA (OAA) Training Programs.

(*f*) *Funding*

Although communities can begin the systems development work outlined above, certain vital services (such as emergency shelters for elders) do not currently exist and require state or federal seed monies. Specialized skills and positions (such as the protective services worker) may not be available in most communities and existing service providers may be unable to guarantee slots or units of service for abuse victims because of existing caseloads or waiting lists. Priority setting at the state level (both programmatic and fiscal) is crucial if a uniform and serious effort is to be made to address the problem of elder abuse. Title XX, Title XIX, Medicare, Title III (OAA) and other sources of services funding should be specifically directed to this problem area.

APPENDIX 2

STATE OF CONNECTICUT,
DEPARTMENT ON AGING,
Hartford, Conn.

TESTIMONY ON CONNECTICUT'S ELDERLY PROTECTIVE SERVICES LAW

My name is Jacqueline Walker. I am the State Ombudsman with Connecticut's Department on Aging. I am here to testify on Connecticut's experience with abuse and neglect of the Elderly.

In July 1977 Connecticut passed two important pieces of legislation dealing with the frail elderly. One bill was "Establishment of the Nursing Home Ombudsmen Office within the Department on Aging" and the other was "An Act Adopting a Reporting Law for Protection of the Elderly." It is concerning this bill that I wish to testify.

At the time this piece of legislation was being introduced to the legislature for passage, the Department on Aging was unable to uncover any statistics concerning the number of elderly persons who had been abused or neglected in the state. We made inquiries of hospitals, emergency rooms, police and family service agencies but none could produce statistical information. Fortunately, however, the legislation passed both the House and Senate with no problems. This success was due, in part, to the effort put forth by Representative Ratchford; former Commissioner on Aging and Chairman of the Governor's Blue Ribbon Committee to Investigate the Nursing Home Industry in Connecticut.

The Ombudsmen Office is funded with $250,000 which covers the salaries of the staff as well as the operating expenses of the office. The staff is comprised of a State Ombudsman and five Regional Ombudsmen who work out of the five health planning and services areas of the state. The Ombudsmen are responsible for receiving and resolving nursing home complaints and problems presented to them by families, friends, patients, and nursing home administrators and which concern the lifestyle and care of the patients in nursing homes, rest homes, and homes for the aged. The Ombudsmen Program went into effect upon passage of the legislation, July 1, 1977. The Protective Services Program went into effect the following January 1978. That program utilizes two state agencies and functions in the following manner. Mandatory Reporters consisting of primarily professional people such as nurses, physicians, police, social workers, ministers, etc. are required to report suspected or known cases of abuse, neglect, abandonment and exploitation of elderly persons 60 years of age or older to the Ombudsmen Office. They may report the case either to the State Ombudsman or to one of the five Regional Ombudsmen. On receipt of such a report, the Ombudsman is required to make an immediate investigation and assessment of the problem. This requires a personal interview with the client as well as contact with as many involved agencies and family members as are available. Once a decision has been made by the Ombudsman that, indeed, there is evidence of neglect, abuse, etc., the Ombudsman discusses the problem and possible solution with the client. The Ombudsman suggests a course of action including types of protective services which will benefit the client in his/her present circumstances.

If the client agrees to this assistance, the Ombudsman then refers the problem to the Elderly Protective Service Unit within the Department of Human Resources. Each district office of the State Department of Human Resources has within it a special unit called the Elderly Protective Service Unit. This unit consists of a supervisor as well as at least one worker assigned, specifically, to the Elderly Protective Services Program. On receipt of a referral from the Ombudsman, the protective services worker visits the client, works up the case and makes provisions for those services to be provided. The types of services may include such things as: a homemaker, home health aide, public health

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nurse, hospitalization, conservatorship, financial management, counseling or psychiatric evaluation. In those cases where a client refuses services which are offered, it is up to the Ombudsman to make a determination as to the competency of the client. Because the Ombudsman spends a fair amount of time with each client she, therefore, has the opportunity of utilizing the mental status quotient as well as other methods of testing in order to ascertain whether or not the patient is capable of making decisions. If, in the judgment of the Ombudsman, the client appears to be incompetent and thus is incapable of making a decision, the Ombudsman then refers the case to the protective services worker and writes those findings. When the protective services worker follows up on the case, he/she will, in turn, make an additional judgement as to the competency of the client before any services are provided. It is important to remember that the purpose of the program is *not* to interfere with the rights of self determination of a person. Rather it is to try to provide services for a person who is in a dire situation and who can benefit from some type of intervention. Frequently, the Ombudsman and/or the protective services worker are able to obtain a psychiatric evaluation of that client. There have been some instances where a client is quite competent, is suffering from a terminal disease, realizes that he/she has only a few months to live and simply does not want any help. In instances such as these we do not interfere. We allow those persons to make their own decisions and live and die as they choose.

Our program has also developed a close working relationship with the probate court system in Connecticut. At the time this program went into effect, another important piece of legislation was passed, namely, "An Act Concerning the Appointment of Conservators." The Ombudsmen as well as the protective services workers met with the probate judges in every town in Connecticut to discuss the responsibility which would be put on the probate judges with the onset of this bill. This bill provides for the appointment of emergency or temporary conservators for those individuals requiring immediate attention and there have been many instances where we have used that vehicle. In some cases the situations have involved immediate hospitalization or delivery of services to the home in order for the person to survive for a few days until medical attention could be obtained.

Since the program has been in effect, there has been an onslaught of cases reported to our office; More cases than we ever anticipated and more serious than we ever anticipated. The Ombudsmen have been astounded, sickened and shocked to see the severity of problems and situations which abound in the community. Problems which, until this time, have gone unnoticed by agencies and community officials. From January 1978 thru April 1979 the total number of reported cases is 937, with the total number of problems associated with those cases 1,065. Of these reported problems there have been 651 concerning neglect. Neglect includes both self neglect, (those elderly who have become incompetent to the extent that they were incapable of providing necessary basic care for themselves) as well as neglect by a caretaker; the caretaker being either a family member, court appointed conservator or non-related person residing in the same home.

There have been 166 cases of physical abuse. From our preliminary statistics, the majority of the abuse has been inflicted by either the grown children of the abusee or by a spouse. In spouse abuse, it has been primarily the husband who has abused the wife. In addition, there have been 127 cases of exploitation and 32 cases of abandonment. There were also 89 cases that we classified as "other" meaning that persons were indeed needing some kind of assistance but technically did not fall under the aegis of abuse, neglect, exploitation or abandonment.

As I indicated before, the Ombudsmen have been astounded at the severity of cases that have been running rampant through the community. Of the 169 towns in Connecticut, 107 have reported cases to date. All mandatory reporters received packets consisting of a brochure outlining their responsibility under the law as well as the report forms. In addition, meetings have been held and are continuing to be held with social service agencies, hospitals, local police, state police and citizens to more fully discuss the program and its implication. In order to more fully emphasize the workings of the program and the types of cases that we receive, I would like to relate to you a few typical examples of cases which were taken from our files from the past year.

1. Mr. and Mrs. A live in an apartment over a store. Their son age 22 lives with them. They are the only tenants in the building. The son has been physi-

cally abusing his parents for many years. The incidents usually follow arguments over money. The son demands money and when his father refuses the son beats him. The last incident was in March 1979 between 10 P.M. and midnight. The mother was struck in the back with a frying pan and the father was clubbed with a stick. According to the parents, the son has been a problem since he was a child. He has had psychiatric help in the past. The parents have had him arrested only to be released by the police. The son told the parents that if they sent him to Connecticut Valley Psychiatric Hospital he would kill them when he got out.

The son refuses to leave the apartment and the parents are terrified. They refuse to return to the apartment. The father is a cardiac patient and a diabetic. He suffered a heart attack after the previous instance of abuse. The recommendations by the Ombudsman were that the son should not be allowed to remain in the community and that he needed psychiatric evaluation and possible placement in the State mental hospital. The parents feel that he needs lifetime placement in the mental hospital. The parents will require a protective environment as well as counseling while the arrangement for the son's care is being made. The report was made to the protective service unit for follow up. These two people arrived at the Veteran's Hospital because of what had just happened. The Veteran's Hospital physician called the Ombudsman who arrived on the scene where this history was taken. The result of this case was that the son had a psychiatric evaluation and was admitted to the Connecticut Valley Hospital. There is some question as what will happen if and when the son gets out. However, when the protective services unit took over the responsibility of this case, they agreed to follow this person the entire time he is in the hospital. When and if the son is discharged from the hospital, they will receive advanced notice of his discharge and can then make the appropriate arrangements for the protection of the parents.

2. Another case concerns a woman who is presently a resident at a home for the aged in Connecticut. According to the complainant, she was kidnapped from her home in Indiana and was brought here against her will. She is arthritic with high blood pressure, and has been hospitalized twice for heart failure in the past month and a half and is currently in intensive care in a local hospital. She does not have anything of her own at this time. Additionally, neither her Social Security check or her pension have been received since her arrival in Connecticut. When I spoke to her she was physically shaken by her ordeal. According to the client, she was kidnapped by her niece and brought to Connecticut. This client has expressed a desire to file criminal charges against her niece for the theft of her money and from the treatment she received from her during the past several months. The exact date of her arrival in Connecticut is as yet unclear. In addition to referring this case to the protective services unit, referrals were also made to the Connecticut Legal Services, and the Social Security Administration. At this particular time the niece is still being sought in New York where she headed after leaving her job in Indiana. The Social Security checks, and the VA pension checks which she had been missing have been returned and are now coming to her at the home for the aged.

3. This case concerns a couple who live together in lower Fairfield county. The couple lives in what was once a lovely home. The house now has an oppressive, foul odor and is scattered with dirt, debris, mail and magazines. The refrigerator in the kitchen is filled with rotten and moldy food. There is no indication that cooking has been done recently. Both the couple and their house are infested with bugs. The Social Worker and the Ombudsman state that the wife is completely confused and disoriented. Her clothes and her person are extremely dirty and unkempt. The husband appears slightly more oriented, although his appearance is also disgustingly poor, however, he does know his age and his name. He claims that the woman is not his wife but just someone who visits and uses his name. He drives a car but his memory is almost non-existant. They are both friendly, gentle people with apparently no concept of their deplorable living conditions or inability to care for themselves. Both of them suffer from malnutrition and appear to be ill in terms of the fact that they have ulcers on their legs and sores on their bodies which appear to be infected. The Ombudsman as well as the Social Worker believe that this couple needs to be removed immediately from their environment in order to receive proper medical and nutritional care. The house needs thorough, extensive exterminating. After a medical and psychological evaluation they, perhaps, will be

able to be maintained at home with appropriate services such as homemaker, meals-on-wheels and if their medical condition indicates, a nurse or home health aide coming in at intervals. If this is not feasible, it would appear that some type of supervised environment will be necessary under the circumstances.

4. Another case concerns a woman who lives alone in a huge, decaying, old house. She lived there with her father until he died three years ago. The woman is obese with a lymphatic disease. Her left leg is distended to the point of elephantitis. Below her knee, where the infected condition exists, her foot is an inhuman looking mass of pustules. At one point the flesh has eroded away and the bone is exposed. This woman denies any problem with her leg. She wraps saran wrap around it to "shrink" it. The odor in the house is a putrid stench that permiates the clothes of anyone that enters. When her father died, a conservator was appointed since a great deal of money and property was left to her. The conservator is a cousin who has very little to do with the client other than pay her bills. The client is fairly lucid in most conversations, however, there are times when she seems to appear to be extremely confused. She has food delivered but has no working refrigerator. She uses only three rooms of the house and she sleeps on a filthy, dirty, torn, stained couch. The floors and carpet are stained with blood and drainage from her foot. She refused any help but absolutely needs medical attention. After referring this case to the protective services worker, the woman was finally taken to the hospital after the necessary action to accomplish this was taken care of by an order from the probate judge. An horrendous scene ensued when the woman was taken screaming out of the house. She is now however, calm and cooperative and is receiving treatment in the hospital. There will possibly be a biopsy and subsequent amputation of her leg. She also has a large mass in her stomach and has been diagnosed by a psychiatrist as a schizophrenic. It is hoped that when this client is finally released from the hospital that she will be able to go back to her home with proper assistance in terms of a homemaker, home health aide, and certainly a visiting nurse, at least initially to assist her so that she can live a relatively normal life.

5. The last case I will recount concerns a mildly retarded woman who attends a day care center in one of the towns in Fairfield County. After much coercion, she finally confided to the director of the day care center that she was having vaginal bleeding and lower abdominal pain, although she was aged 69. The director of the day care center notified the Ombudsman that she suspected that there might be some kind of problem going on within her home. The woman and her husband live with her brother-in-law because they had been evicted from their home. The Ombudsman finally elicited the information that the woman was being raped by the brother-in-law. After confessing, the client appeared to be very afraid of having admitted what was occurring and feared some sort of reprisal. When asked, she finally agreed to press charges against the brother-in-law for this act. The police were notified and the offender arrested. The woman and her husband are now living in the apartment and the brother-in-law has been sent to jail awaiting trial.

I have attempted to relate some cases which we consider to be typical of the problems received in our program every day. A day doesn't go by that each of the Regional Ombudsmen does not receive at least 3 reports of some kind concerning neglect, abuse or exploitation. The program is time consuming and keeps the Ombudsmen constantly on the go especially when added to the nursing home problems which continue to come in as usual.

We realize fully that as the program continues and as more and more people become cognizant of our work that we will be inundated with problems. There is no question in our minds as to the importance of the program and we realize fully that there are endless numbers of problems which are still hidden away waiting to be uncovered.

From our brief experience, we can readily say that abuse and neglect are prevalent in all walks of life. There are equally as many problems in affluent neighborhoods as there are in poverty areas, in rural as well as urban areas and the problems are found in all ethnic groups. Those over 75 report most frequently than any other age.

The Ombudsmen Office anticipates that it will be able to research and analyze elderly injuries in order to document those injuries which can only be attributed to mistreatment and abuse rather than to accidents. In addition, we hope to investigate and analyze the abuser, as well as the conditions which may encourage or invite abuse.

As yet, we have only touched the surface of the problem. Time will tell what the future holds for those of us who work with this type of program as well as for those of us who live to become one of the fortunate or unfortunate elderly citizens.

Attached is a copy of Connecticut's Elderly Protective Service Law for your information as well as a brochure which was mailed to every mandatory reporter in the state.

[Substitute House Bill No. 8039]

Public Act No. 77–613

AN ACT Adopting a reporting law for protection of the elderly.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) For purposes of this act:

(1) The term "elderly person" means any resident of Connecticut who is sixty years of age or older.

(2) An elderly person shall be deemed to be "in need of protective services" if such person is unable to perform or obtain services which are necessary to maintain physical and mental health.

(3) The term "services which are necessary to maintain physical and mental health" includes, but is not limited to, the provision of medical care for physical and mental health needs, the relocation of an elderly person to a facility or institution able to offer such care, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, protection from health and safety hazards, protection from maltreatment the result of which includes, but is not limited to, malnutrition, deprivation of necessities of physical punishment, and transportation necessary to secure any of the above stated needs, except that this term shall not include taking such person into custody without consent except as provided in this act.

(4) The term "protective services" means services provided by the state or other governmental or private organizations or individuals which are necessary to prevent abuse, neglect, exploitation or abandonment. Abuse includes, but is not limited to, the wilful infliction of physical pain, injury or mental anguish, or the wilful deprivation by a caretaker of services which are necessary to maintain physical and mental health. Neglect refers to an elderly person who is either living alone and not able to provide for oneself the services which are necessary to maintain physical and mental health or is not receiving the said necessary services from the responsible caretaker. Exploitation refers to the act or process of taking advantage of an elderly person by another person or caretaker whether for monetary, personal or other benefit, gain or profit. Abandonment refers to the desertion or wilful foresaking of an elderly person by a caretaker or the foregoing of duties or the withdrawal or neglect of duties and obligations owed an elderly person by a caretaker or other person.

(5) The term "caretaker" means a person who has the responsibility for the care of an elderly person as a result of family relationship or who has assumed the responsibility for the care of the elderly voluntarily, by contract or by order of a court of competent jurisdiction.

(6) "State ombudsman" and "regional ombudsmen" mean the persons appointed by the commissioner on aging under the provisions of section 1 of substitute house bill number 8037 of the current session.

Sec. 2. (a) Any physician or surgeon registered under the provisions of chapter 370 or 371 of the general statutes, any resident physician or intern in any hospital in this state, whether or not so registered, any registered nurse, any nursing home administrator, nurses aide or orderly in a nursing home facility, any person paid for caring for a patient in a nursing home facility, any staff person employed by a nursing home facility, any patients' advocate and any licensed practical nurse, medical examiner, dentist, osteopath, optometrist, chiropractor, podiatrist, social worker, coroner, clergyman, police officer, pharmacist or physical therapist, who has reasonable cause to suspect or believe that any elderly person has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such abuse, neglect, exploitation or abandonment, or who is in need of protective services, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the commissioner on aging or to the person or persons designated by him to receive such reports. Any person required to report under the provision of this section who fails to make such report shall be fined not more than five hundred dollars.

(b) Such report shall contain the name and address of the involved elderly person, information regarding the nature and extent of the abuse, neglect, exploitation or abandonment, and any other information which the reporter believes might be helpful in an investigation of the case and the protection of such elderly person.

(c) Any other person having reasonable cause to believe that an elderly person is being, or has or who is in need of protective services may report such information in any reasonable manner to the commissioner or his designee.

(d) Any person who makes any report pursuant to this act, or who testifies in any administrative or judicial proceeding arising from such report shall be immune from any civil or criminal liability on account of such report or testimony, except for liability for perjury, unless such person acted in bad faith or with malicious purpose.

Sec. 3. (a) The commissioner upon receiving a report that an elderly person allegedly is being, or has been, abused, neglected, exploited or abandoned, or is in need of protective services shall cause a prompt and thorough evaluation to be made, through the appropriate regional ombudsman, to determine the situation relative to the condition of the elderly person and what action and services, if any, are required. The evaluation shall include a visit to the named elderly person and consultation with those individuals having knowledge of the facts of the particular case. Upon completion of the evaluation of each case, written findings shall be prepared which shall include recommended action and a determination of whether protective services are needed. The person filing the report shall be notified of the findings, upon request.

(b) Each regional ombudsman shall maintain a registry of the reports received, the evaluation and findings and the actions recommended, and shall furnish copies of such data to the department on aging for a statewide registry.

(c) Neither the original report nor the evaluation report of the regional ombudsman shall be deemed a public record or be subject to the provisions of section 1-19 of the general statutes. The name of the person making the original report or any person mentioned in such report shall not be disclosed unless the person making the original report specifically requests such disclosure or unless a judicial proceeding results therefrom.

Sec. 4. (a) If it is determined that an elderly person is in need of protective services, the regional ombudsman shall refer the case to the department of social services for the provision of necessary services, provided the elderly person consents. If the elderly person fails to consent and the regional ombudsman has reason to believe that such elderly person lacks capacity to consent, the regional ombudsman shall refer the case to the department of social services for a determination pursuant to section 7 of this act of whether a petition for appointment of a conservator should be filed.

(b) If the caretaker of an elderly person who has consented to the receipt of reasonable and necessary protective services refuses to allow the provision of such services to such elderly person, the commissioner of social services may petition the superior court or the probate court for an order enjoining the caretaker from interfering with the provision of protective services to the elderly person. The petition shall allege specific facts sufficient to show that the elderly person is in need of protective services and consents to their provision and that the caretaker refuses to allow the provision of such services. If the judge finds that the elderly person is in need of such services and has been prevented by the caretaker from receiving the same, the judge may issue an order enjoining the caretaker from interfering with the provision of protective services to the elderly person.

Sec. 5. Any person, department, agency or commission authorized to carry out the duties enumerated in this act shall have access to all relevant records, except that records which are confidential to an elderly person shall only be divulged with the written consent of the elderly person or his representative. The authority of the department of social services, and the department on aging under this act shall include, but not be limited to, the right to initiate or otherwise take those actions necessary to assure the health, safety and welfare of any elderly person, subject to any specific requirement for individual consent, and the right to authorize the transfer of an elderly person from a nursing home.

CONSENT

SEC. 6. (a) If an elderly person does not consent to the receipt of reasonable and necessary protective services, or if such person withdraws the consent, such services shall not be provided or continued, except that if the commissioner of social services has reason to believe that such elderly person lacks capacity to consent, he may seek court authorization to provide necessary services, as provided in section 7 of this act.

(b) The department of social services, within ten calendar days of the referral of any cases for the provision of protective services, shall furnish the regional ombudsman a written report outlining the intended plan of services. The regional ombudsman shall have the right to comment on the proposed plan, and a copy of the regional ombudsman's comments shall be forwarded to the state ombudsman for subsequent action, if required.

APPOINTMENT OF CONSERVATOR

SEC. 7. (a) If the commissioner of social services finds that an elderly person is being abused, neglected, exploited or abandoned and lacks capacity to consent to reasonable and necessary protective services, he may petition the probate court for appointment of a conservator of the elderly person pursuant to the provisions of chapter 779 of the general statutes, in order to obtain such consent.

(b) Such elderly person or the individual, agency or organization designated to be responsible for the personal welfare of the elderly person shall have the right to bring a motion in the cause for review of the probate court's determination regarding the elderly person's capacity or an order issued pursuant to this act.

(c) The probate court may appoint, if it deems appropriate, the commissioner of social services to be the conservator of the person of such elderly person.

(d) In any proceeding in probate court pursuant to provisions of this act, the probate court shall appoint an attorney to represent the elderly person if he is without other legal representation.

USE OF OTHER HUMAN SERVICE AGENCIES

SEC. 8. (NEW) In performing the duties set forth in this act, the regional ombudsmen and the department of social services may request the assistance of the staffs and resources of all appropriate state departments, agencies and commissions and local health directors, and may utilize any other public or private agencies, groups or individuals who are appropriate and who may be available.

SEC. 9. Subsequent to the authorization for the provision of reasonable and necessary protective services, the department of social services shall initiate a review of each case within forty-five days, to determine whether continuation of, or modification in, the services provided is warranted. A decision to continue the provision of such services should be made in concert with appropriate personnel from other involved state and local groups, agencies and departments, and shall comply with the consent provisions of this act. Reevaluations of each such case shall be made every ninety days thereafter. The department of social services shall advise the appropriate regional ombudsman of the decisions relative to continuation of protective services for each such elderly person.

SEC. 10. Prior to implementation of any protective services, an evaluation shall be undertaken by the department of social services, pursuant to regulations which shall be adopted by the commissioner of social services, in accordance with chapter 54 of the general statutes, regarding the elderly person's financial capability for paying for the protective services. If the person is so able, procedures for the reimbursement for the costs of providing the needed protective services should be initiated. If it is determined that the person is not financially capable of paying for such needed services, the services shall be provided in accordance with policies and procedures established by the commissioner of social services for the provision of welfare benefits under such circumstances.

SEC. 11. If as a result of any investigation initiated under the provisions of this act, a determination is made that a caretaker or other person has abused, neglected, exploited or abandoned an elderly person, such information shall be

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referred in writing to the appropriate office of the state's attorney, which shall conduct such further investigation, if any is deemed necessary and shall determine whether criminal proceedings should be initiated against such caretaker or other person, in accordance with applicable state law.

SEC. 12. Regulations shall be promulgated by the commissioner on aging, in conjunction with the commissioner of social services, to carry out the provisions of this act.

SEC. 13. The department on aging shall reimburse the general fund for any amounts expended from the funds appropriated to the department of social services for the purposes of this act.

SEC. 14. The sum of fifty thousand dollars is appropriated to the department of social services from the sum appropriated to the finance advisory committee, under section 1 of special act 77–46, for 1977 acts without appropriations, for the personnel necessary to coordinate and participate in the reporting, investigation and protective service activities required by this act and for the resources needed to provide such protective services.

SEC. 15. This act shall take effect January 1, 1978.

If you are a physician, intern, registered nurse, licensed practical nurse, medical examiner, dentist, osteopath, optometrist, chiropractor, podiatrist, social worker, coroner, clergyman, police officer, pharmacist, physical therapist, nursing home administrator, an aide, orderly, or nursing home employee, this pamphlet concerns you.

It explains your legal responsibilities under Connecticut's new law on protective services for the elderly.

WHERE AND HOW TO REPORT

Anyone who suspects that an elderly person is the victim of abuse, neglect, exploitation, or abandonment, should call the Regional Ombudsman listed below. The report should be made to the Ombudsman in the area in which the problem occurs or to the State Ombudsman.

State Ombudsman; Jacqueline C. Walker, Department on Aging, 80 Washington St., Hartford, Ct. 06115.

REGION I

Southwestern—covering the towns of: Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, Wilton.

Ombudsman; Judith Sugarman, 276 Park Ave., Bridgeport, Ct. 06604—Tel. 366-6761.

REGION II

South Central—covering the towns of: Ansonia, Bethany, Branford, Derby, East Haven, Guilford, Hamden, Madison, Meriden, Milford, North Branford, North Haven, Orange, Oxford, Seymour, Shelton, Wallingford, West Haven, Woodbridge.

Ombudsman; Frances Impellizzeri, 614 Campbell Ave., Second Flr., West Haven, Ct. 06516—Tel. 789-6913.

REGION III

Eastern—covering the towns of: Ashford, Bozrah, Brooklyn, Canterbury, Chester, Clinton, Colchester, Columbia, Coventry, Cromwell, Deep River, Durham, Eastford, East Haddam, East Hampton, East Lyme, Essex, Franklin, Griswold, Groton, Haddam, Hampton, Killingly, Lebanon, Ledyard, Lisbon, Lyme, Mansfield, Middletown, Montville, New London, North Stonington, Norwich, Old Lyme, Old Saybrook, Plainfield, Pomfret, Portland, Preston, Putnam, Salem, Scotland, Sprague, Sterling, Stonington, Thompson, Union, Voluntown, Willington, Windham, Woodstock.

Ombudsman; Meredith Savage, 90 Toun Street, Norwich, Ct. 06306—Tel. 886-0521.

REGION IV

North Central—covering the towns of: Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hartland, Hebron, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, Windsor Locks.

Ombudsman; Lynn Algarin, 1229 Albany Ave., Hartford, Ct. 06112—Tel. 525-9053.

REGION V

Northwestern—covering the towns of: Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Harwinton, Kent, Litchfield, Middlebury, Middlefield, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newton, Norfolk, North Canaan, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Winchester, Wolcott, Woodbury.

Ombudsman; Sheila Calhoun, 20 East Main St., Rm. 203, Waterbury, Ct. 06702—Tel. 573-0866.

PROTECTIVE SERVICES FOR THE ELDERLY

Under a new law which took effect in 1978, the State of Connecticut Departments on Aging and Social Services are working together to provide help to elderly persons 60 years of age and older who are victims of abuse, neglect, exploitation, or abandonment.

The new law, P.A. 77-613, authorizes these two state agencies to cooperate in the investigation of any reported cases of abuse, neglect, exploitation, or abandonment of the elderly. If the investigation shows the older person is in need of protective services, the State may intervene and arrange for the care of the aged individual through relatives, or friends, or a court appointed conservator. The State may, with the consent of the elderly person or a conservator, provide for such services as day care, homemaker services, chore services, meals on wheels, health care, and shelter.

MANY OBLIGED TO REPORT

The new law mandates that a wide range of persons whose work brings them into contact with the elderly report cases of abuse, neglect, exploitation, or abandonment to one of six Department on Aging Ombudsmen listed in this pamphlet.

Those persons required to report to the Ombudsmen include: physicians, surgeons, interns, registered nurses, licensed practical nurses, medical examiners, dentists, osteopaths, optometrists, chiropractors, podiatrists, social workers, coroners, clergymen, police officers, pharmacists, physical therapists, nursing home administrators, nursing home aides, nursing home orderlies, all nursing home staff, regional ombudsmen for the aging, patient advocates.

TIMELY REPORTING REQUIRED

The mandatory reporters listed above are required to report to the Ombudsman for Aging within five calendar days of the time the suspected abuse, neglect, exploitation, or abandonment is discovered.

The reporter should provide the Ombudsman with at least the name and address of the involved elderly person and information regarding the nature and extent of the abuse, neglect, exploitation, or abandonment.

PENALITIES AND IMMUNITY FOR REPORTERS

Any mandatory reporter who has reasonable cause to suspect or believe that an elderly person has been abused, neglected, exploited, or abandoned, and fails to report as required, shall be fined not more than $500.

Legal immunity from any civil or criminal liability related to a mandatory report is provided to those who report in good faith, except for cases of perjury.

THE RIGHTS OF THE ELDERLY PERSON

There are a number of provisions tailored to protect the rights of the elderly persons who may need protective services.

Consent—Elderly persons must give their consent before services are arranged for them.

Formal Hearing on Competency—If it is felt that an elderly person lacks the capacity to give consent for State intervention, a petition for custody of the person may be filed in Probate Court. The elderly person must be represented by an attorney during these proceedings.

DEFINITIONS

"Abuse" includes, but is not limited to, the willful infliction of physical pain, injury or mental anguish, or the willful deprivation by a caretaker, of services which are necessary to maintain physical and mental health.

"Neglect" refers to an elderly person who is either living alone and not able to provide for him/herself the services which are necessary to maintain physical and mental health or is not receiving necessary services from the responsible caretaker.

"Exploitation" refers to the act or process of taking advantage of an elderly person by another person or caretaker whether for monetary, personal, or other benefit, gain or profit.

"Abandonment" refers to the desertion or willful forsaking of an aged person by a caretaker or the foregoing of duties and obligations owed an elderly person by a caretaker or other person.